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ANNUAL REPORTS

of the
COUNTY MEDICAL OFFICER
and the
PRINCIPAL SCHOOL MEDICAL
OFFICER

for the Year
1969

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INTRODUCTION

CO-ORDINATION

In the introduction to my last three Annual Reports I have tried to keep the Health Committee informed of the general trend of events affecting the services. I have endeavoured to make some inspired guesses based on the reports emanating from Government sources and from Parliamentary activities, as well as from material being discussed in professional circles. I have also attempted to show that the pattern which seems to be emerging will be dependent for its success on adequate communication between the various services, and to point out that the considerable advances made in preventive medicine should not be lost sight of or jeopardised. I have also sought to show that preventive medicine, in order to be successful, must not remain static, and that to its own and everybody else's advantage it must be prepared for change and modification.

The general pattern which is emerging is well known to the Committee and broadly speaking amounts to a unification of all three branches of the health services outside local government and for the welfare and social services, including some which at the moment are being carried out by health departments, to join together within new social service departments of local authorities, thus creating an administrative and functional gap between the medical and social services. Events of the past year have reinforced this trend which has the effect of considerably disrupting the health departments of local health authorities. This in itself is not an important matter except for its effect on recruitment but what does seem to need careful consideration is whether these suggested steps will be of advantage or otherwise to the general public to be served.

Three pieces of legislation inaugurated during the past twelve months are important in this respect.

(1) *The Local Authority Social Services Act, 1970* which is in effect a full implementation of the well known Seebohm report which creates new social service departments of local authorities as already described above. At the time of writing we are left a little in the dark as to what will in fact happen because a Secretary of State, still to be determined, has the power to put individual sections of the Act into operation, either fully or partially, at various times, by order, as thought fit. We still await the new Government's wishes in this direction.

(2) *The Education (Handicapped Children) Act, 1970* which puts into effect the announcement of the previous Prime Minister and legislates for the transfer of junior training centres and accommodation for severely subnormals in the

community, and for the education of severely subnormal children in hospital to education departments. Here again the Secretary of State will determine under order when this transfer shall take place, and we therefore await the new Government's decision on the effective date. This is causing considerable disquiet as to their future amongst training centre staff, and one hopes that the difficult discussions with representatives of the teaching profession now taking place will lead to a humane and satisfactory solution.

(3) *The Chronically Sick and Disabled Persons Act, 1970*. Although this deals largely with welfare matters it has two important provisions which have considerable bearing on the health service: (a) Regional Hospital Boards are being urgently pressed to secure as far as practicable the separation of the young chronic sick from the elderly in hospital accommodation, and (b) education authorities are strongly urged to secure special educational facilities for children who suffer from the dual handicap of blindness and deafness, for those suffering from autism and for those suffering from dyslexia.

These new measures reinforce the feeling of need for a co-ordinating mechanism to knit together the various concepts and desires which are continuing to flow freely.

However, an anxiety about the present trends is expressed in the Central Health Services Council's Report to the Secretary of State for the year 1969 which has just been published, and which, after considering the Seebohm report makes a statement of which the Committee should be aware:

"6. At their meeting on 14th January, the Council considered the Report of the Committee which had been set up to review the organisation and responsibilities of the local authority personal social services in England and Wales in so far as it affected the health services. After hearing the comments of the Standing Medical, Standing Nursing, Standing Maternity and Midwifery and Standing Mental Health Advisory Committees on the Report, the Council discussed the advice which they wished to submit to the Secretary of State for Social Services and the Secretary of State for Wales. The details of this advice were agreed at the Council's meeting on 15th April.

7. Whilst recognising the need for closer integration of medical and social work, the Council considered:

(a) that the Report failed to take into account the extent to which co-operation between the medical profession and social workers has developed recently and overlooked the difficulties caused by shortages of manpower and resources;

(b) that the proposed separation of medical and social work would not only be administratively disastrous, but would be to the great disadvantage of the patient;

(c) that there would be insufficient trained social workers available to enable social service departments to be set up within the time limit proposed by the Report;

(d) that the Home Help Service should remain the responsibility of the health departments;

(e) that the role of the medical advisers to the Social Service Departments and the way in which their advice should be followed up has not been studied in sufficient detail;

(f) that the compiling of psychiatric case registers other than for research purposes and by those fully qualified to undertake such a task is impractical and undesirable;

(g) that the Report's recommendations on child guidance did not appreciate fully the implications of such care;

(h) that the Report pays insufficient attention to the medico-social problems of women discharged early after hospital confinements;

(i) that the circumstances of child-birth offer a clear example of concurrent need of both medical and social care and any future re-organisation of the health, welfare and social services should not result in a lessening of the quality of service, in both fields, provided for families in this situation; and

(j) that there should be an assessment of existing experiments in co-ordination between the health and welfare services, that the problem should be further studied in pilot schemes and that no decision should be taken on the Report's recommendations until the Report of the Royal Commission on Local Government had been received and considered and until the Secretaries of State had reached a decision on the proposals outlined in the Green paper."

This may be considered to be somewhat of a rearguard action at this point in time but it is also echoed in the fact that communications in recent times from the local authorities associations shows a unanimity of feeling that there should be a deferment of implementation of these measures until more is known about the future of local government and of the health services.

Truly it can be said that we may well have been far more preoccupied with the development of administrative structures than with what happens at field level. The concept of a team approach to personal problems, probably largely in the context of group medical practice, must not be lost sight of, and it is becoming increasingly recognised as the right approach.

Looked at in this light we once again have to consider the co-ordinating mechanism which this team approach will need, and I suggest that it is because of

these considerations that the proposed reorganisation on the medical side has brought to the fore the concept of the community physician. I am glad to see that the Government has set up the Hunter Working Party to consider as an urgent matter the question of future administration which embraces this concept.

It is interesting to note how the concept of the community physician has developed as between the two Green Papers on the National Health Service, one published in 1968 and the other in 1970. In the 1968 paper we have the concept of the medical officer of health extending his role into that of the community physician and being a specialist in community medicine, which, in the context of the paper, seems to involve medicine outside the hospital. This is of course, the field in which medical officers of health have made considerable progress. When, however, we turn to the 1970 paper on the work of the community physician as set out in paragraphs 49 to 52, the community physician has grown in stature and has become a person advising and administering across the whole breadth of the health services, and including some advisory and executive functions on behalf of local authorities. This is a considerable step forward in a very short time. Members of the Health Committee have already received a copy of the pamphlet which I wrote on the Community Physician and which was kindly published in April, 1970, by the County Councils Association. This was written because of my anxiety about the future efficiency of field work and for the preservation of preventive medicine. The pamphlet was written in order to ensure that these problems were not lost sight of in the multitude of discussions which have been taking place in the past two years. I am reproducing below some extracts from the pamphlet to illustrate the points I have made above:

From the Preface by Colonel G. P. Shakerley, Chairman of the Association's Executive Council

“No matter how the National Health Service is reorganised, the Association believe that health, social, educational, and other local government services will only match up to the needs of the public if they are co-ordinated and if there are close-working relationships between the professions concerned.”

“This paper is published by the Association as a contribution to the discussion of what will be one of the most important aspects of any National Health Service reorganisation, an aspect which the Green Paper itself acknowledged must be given more detailed study than it has received so far.”

Administrative Unity must mean Functional Unity

“There are serious divisions of function in our health services, but, even in those countries where there has been administrative unity for some little time, similar divisions of function can still exist, especially between care outside the hospital and that in the hospital and specialist services. It would appear that clinicians, left to themselves, are unable to produce the complete service needed by the individual.”

“Individuals will only get what they need in this complicated world of medical science if competent, understanding men have organised the deployment of mutually supporting services to that end. Such organisation is essential if this work is to be effective.”

“A general practitioner, in order to give a complete service to his patients, must have the assistance of all his clinical colleagues and of those workers in preventive medicine; therefore, a good deal of internal co-ordination within the medical services will be required. He also requires in addition the supporting services from the social side, but these will have been separated from the medical field into the new social work department. We cannot afford to have a vacuum in that sphere of activities which has been increasingly the responsibility of the medical officer of health in recent years.”

“There are areas of development, co-operation, easement, research, stimulation, experimentation, preventive action and epidemiology, all vitally needing to be explored and executive action taken to ensure smooth running of a complete service. The emphasis should be on comprehensiveness and it will not be enough to have an administrative umbrella over a still-divided service; under such circumstances group practice would not have achieved its objective of closer links with the hospital and preventive services.”

Support for the Community Physician Concept

“The Royal Commission on Medical Education¹ considers that medical leadership in community medicine is as important as ever and stresses the need for specialist training and practice in this branch of medicine.”

“The Seebohm Committee Report,² in referring to the future of the local authority health department, recognises that their recommendations would lead to substantial changes in its functions to such an extent that concern is expressed as to whether local health and school health departments, or what remains of them after their proposed changes, would in fact remain viable as working units. The Seebohm Report indicates that the implications of a breakdown of these services would be very serious for the local community and for the National Health Service. Speaking of the new social welfare department, the Report recognises the dependence of this department on many of the activities of the local health department. It would be disastrous if there were insufficient communication between the social workers and the medical workers, and the prospect of improvement is not made any better by the realisation that heroic efforts have had to be made, both in the medical and social fields, in order to improvise what communications do now exist. The Seebohm Report goes on to say that major new tasks of community medicine are being left undone, and little use is being made of modern epidemiology to provide an intelligence system relevant to local needs in health and health services. To overcome all these difficulties, a demand is made for leadership in organisation, in the promotion of health and preventive medicine, and it is recognised that it would be tragic if the vital contribution of the local health department were weakened, even temporarily. The need of a community physician to fulfil this role is considered by the Committee to be urgent.”

How the Community Physician can assist the Clinician

“Obviously, the community physician will have a responsibility for assessing the health needs of the community as a whole and should have responsibility for promoting measures to provide for these total community needs, either by direct action or by stimulating others. The community physician must, therefore, have a very close relationship with local government social and environmental services.

Within the health service proper, the community physician would also have a co-ordinating and gap filling role in order to stimulate the preventive aspects of medical work and to provide an executive outlet for it.

As already referred to, this was recognised in the Sheldon Report which recommended that the medical officer of health should organise the child health service as a whole. Similarly, the Royal Commission on the law relating to mental illness³ considered it essential that the general direction of the community services for the mentally disordered should be in the hands of the medical officer of health. More recently, the Seebohm Committee, commenting on the need for team work in the mental health field and for local medical and personal social services to be coherently organised and co-ordinated, have expressed the view that the contribution of the public health doctor, the community physician of the future, responsible for a defined population, will be crucial.⁴

Current experience in the work of a modern health department also supports the necessity for stimulus and executive function by someone to bridge the gaps between the clinical services. We need only mention the stimulus given to a better medical service by the promotion of health centres, attachment of staff to general practitioners, development of computer services by local authorities for medical purposes, and the large number of schemes which have been developed on the hospital side by joint endeavours such as conjoint midwifery schemes, early discharge policies, the development of out-patient surgery, joint management of the care of the elderly and the mentally disordered, the arrangements for the common use of and appointment of mental welfare officers between hospitals and local health authorities, and the increasing practice of late of inviting medical officers of health into the early planning stages of the building of new hospitals which are unable to function fully without a complete supporting domiciliary service. All these are practical issues which have had fruitful results.

The list of endeavours of this kind is large and growing larger day by day. The community physician, therefore, has a formidable task—largely because of the multifactorial role which he will have to undertake.

In general terms, it is therefore clear that the three branches of the service are now completely interdependent as the result of changes of attitude in the last ten or twenty years. There is a co-ordinating role for a community physician, who needs quite simply to offer his own particular skills to his colleagues in just the same way as any other doctor does.”

The Future of Preventive Medicine

“Preventive medicine had its origin over a hundred years ago in attempting to deal with the grossly bad environment which was then quite common and also with the severe epidemics of fatal diseases. It was in this background that local government was begun, and preventive medicine can be said to be one of the original reasons for the formation of our present system of local government. Under the aegis of local government, preventive medicine has continued to have an interest in environmental matters but has advanced to the field of personal health and the prevention and early detection of non-infectious diseases.

Now, for the first time, the association of preventive medicine with local government is being investigated bearing in mind the need for a comprehensive health service. In the past, preventive medicine has proved its flexibility and no doubt this will serve it in good stead in the future. Many of its successes have been in the field of primary prevention. This work will still be as necessary as ever, but with a closer link in future with the clinical services; important aspects of secondary and tertiary prevention will be capable of increased emphasis. Clinicians have had their practice altered out of all recognition by the successes achieved in primary prevention. It can be assumed that, eventually, similar change will occur as secondary and tertiary prevention becomes more assiduously pursued.”

The Community Physician's Field of Work

“He will practice preventive medicine in the way already outlined generally, within the area of any health authority and his personal standing with his professional colleagues will matter far more than the number of staff he employs.

On preventive medical matters, he will be the obvious person to liaise with the medical administrative structure within the hospital created by the ‘Cog-wheel’ Report.⁵

Pursuit of the epidemiology of non-infectious diseases and the promotion of measures against the enormous anti-health developments of modern times, such as smoking, drug-taking etc.

The control of infectious disease within the hospital.

The control of epidemics, which makes it necessary for a close link to be kept with hospitals, general practitioners and local authorities.

He must co-ordinate and provide medical advice to the new Social Welfare Departments of local authorities. If the recommendations of the Seeborn Report were followed literally, the new Social Welfare Departments would make individual arrangements for their medical advice and this would lead to

confusion and fragmentation. By co-ordinating such advice, the community physician would be in a better position to practise preventive medicine in the community.

Whatever the final arrangements reached between the Department of Health and Social Security and the Department of Education and Science, the school health service will still need the guiding hand of a new type of school medical officer who would, presumably, be within the sphere of control of the community physician who would need to co-ordinate the application of consultant and general practitioner skills in the school health service. The importance of this has been stressed recently by Whitmore⁶ when he points out that, so long as medical, educational and social services continue to develop their diagnosis and assessment facilities independently, duplication of staff and effort is inevitable. Liaison between them is made more difficult and tiresome, and treatment or management may be limited to facilities each agency itself provides. It is obviously in the interests of the child that there should be a continuing process of assessment which involves not only the hospitals and general practitioners but work in the nursery or school in conference with teachers and others, including parents. Purely clinical skills are not enough for the school health service as pointed out by Francis⁷ when he says that, for both the community paediatrician and the school physician, an element of epidemiology is also required if the services in which they work are to have an adequate preventive orientation. Health education in schools will be a particularly difficult and important task of the community physician. In dealing with the medical and hygienic content of social curricula being conducted by teachers, his special advice will be asked in the counselling of adolescents with their specific problems.

The development of a new role for the school physician to concentrate his work on those children needing his attention and particularly handicapped pupils and their assessment in relation to education. This will involve developing techniques for the hearing and vision screening of very young children amongst other things.

The organisation and evaluation of health education for other groups in the community will be necessary in order to link together the resources of the hospital and general practitioner with the preventive services.

However the community mental health services of the future are reorganised, it cannot be denied that there is a substantial medical content of the work to be carried out and it is in this field that the community physician must exert his influence if there is not to be a breakdown in communications.

The promotion of schemes with his staff in conjunction with consultants and general practitioners to involve themselves, in the proper place, with developmental paediatrics.

The organisation of immunisation programmes.

The identification of special groups who require help and initiating action needed for them to get that help. Certain categories of children and the elderly will be obvious recipients for this attention.

The organisation and evaluation of selective screening processes, which can only start as a preventive measure but often end up with general practitioner and hospital service needs.

The control of the general supportive services left to him after the Seebohm Report has been implemented; for instance, the domiciliary midwifery, health visiting and home nursing, the ambulance service, and any other transport services which may be introduced into the medical services.

Bridging the gap between the hospital and the domiciliary services in connection with the rehabilitation of discharged persons, and ensuring that rehabilitative services are available.

Family planning, although also a function of hospitals and general practitioners, will need to be supplemented and co-ordinated by the community physician if those people who need family planning but do not seek it are to be reached—for instance, problem families.

Playing an important part in computer and record linkage activities.

There will be a continuing need for medical expertise in the assessment and control of hazards in the environment: the problems of air pollution and water purity, of food hygiene, noise nuisances housing, etc., will still need some medical advice, even though the executive roles are left to others. *On the State of the Public Health, 1968*⁸ raises this problem of the relationship of medical advice to environmental matters in local authority work and implies that, although the essentially medical aspects of the environmental problems may not form a large enough part of the work of the district to enable the medical adviser to keep himself fully expert, he will have a background of local knowledge and personal contact within the medical and other spheres, which will be essential for the proper conduct of environmental hygiene. Tyser⁹ goes further than this and suggests that medical policing in public health will continue to be necessary and that a statutory position for the community physician may be needed in this respect.

The administrative control of a number of miscellaneous medical and social items, such as arrangements for the inspection of private nursing homes, National Health chiropody schemes, and recuperative care.

The organisation of occupational health services, at least as they affect the health authorities themselves. He may also need to give advice, or arrange for advice to be given, on medical matters to outside bodies; for instance, voluntary bodies.

Apart from executing remedies or arranging for this to be done on the results of his own research, the community physician would need to act on national surveys where appropriate and similarly on regional surveys: for instance, the Second Report of the British Perinatal Mortality Survey¹⁰ and the Five-Yearly Reports on Confidential Enquiries into Maternal Deaths¹¹ immediately spring to mind since they have in them many matters which challenge preventive medicine.

The above list cannot be comprehensive for the simple reason that the community physician's duties, like his predecessor—the medical officer of health, would be constantly changing.”

The Departmental Medical Officer

“Quite obviously, there must be a complete reorientation of the duties of the present departmental medical officer in local health authority departments, who are carrying out this kind of clinical work. These officers will need to become more specialised and to be retrained in their new role; simultaneously general practitioners, quite rightly, will take a greater interest in certain aspects of preventive medicine. Experiments in the retraining of departmental medical officers are already going on in some parts of the country with considerable success and it seems that such retrained officers will be very much needed in the future.

There is well documented evidence¹² that some of the traditional duties of the departmental medical officer could well be discarded in favour of a more specialised type of work. Fewer of these specialised officers on the staff of the community physician would be needed, but they would be able to deploy their skills over a wider area.

Not all general practitioners would have the time or the inclination to involve themselves in this kind of work, but they should be encouraged to do so if they are prepared to specialise in it. Some of the departmental medical officer's current work, however, could well be undertaken at the present time by the general practitioners, should they be so inclined. However, one has to provide a reasonably uniform service throughout the country, and one cannot afford to allow it to be too patchy; hence full-time officers will still be needed.”

Conclusion

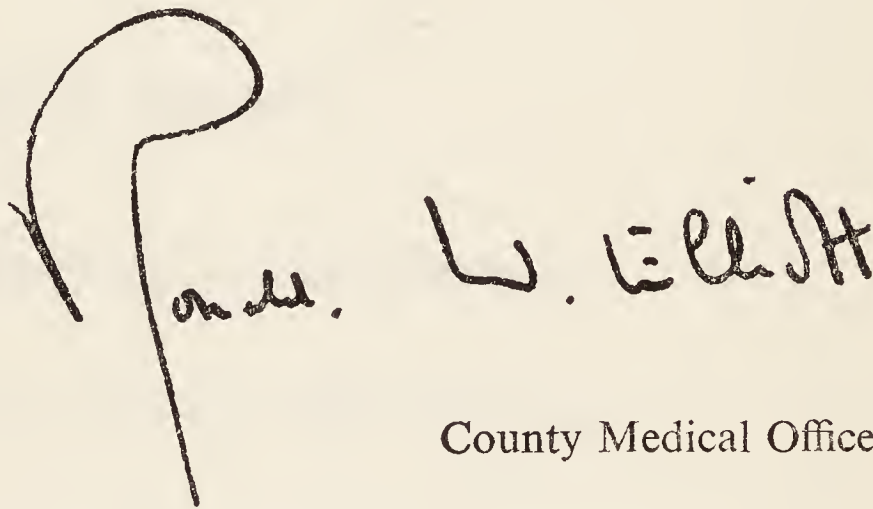
“Medical services are too complex and costly to be left to random growth. What this country lacks and must provide is the community physician with powers and facilities to enable him to give his clinical colleagues the support in this matter they so generally require.”¹³

I would draw readers' attention to the special reviews later in this report. They are accounts of new activities taking place within the department and illustrate not only the variety of work involved in the department but its constantly changing and progressing character.

I would like to thank members of the health department staff for their continued support in all our endeavours. To those who have left us I wish them success, and I sincerely hope that those who have joined us within the last twelve months will find a stimulating atmosphere in which to work.

Health Department,
Wood Street,
Wakefield.

August, 1970.

A large, stylized handwritten signature in dark ink, appearing to read 'W. Ellis'. The signature is written in a cursive, flowing style with a large loop at the beginning.

County Medical Officer

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SPECIAL REVIEWS

Introducing Computers to the Health Department

Day Care Facilities for Children Under Five Years

‘The Pulse Quickens’: Home Nursing Service

Renal Dialysis at Home

**The Development of Swimming Pools at Training Centres
As Projects For Voluntary Body Participation**

Spina Bifida Cystica

INTRODUCING COMPUTERS TO THE HEALTH DEPARTMENT

Huw W. S. Francis, Deputy County Medical Officer

When the County Treasurer recommended to the Finance Committee the purchase of a larger computer (the Honeywell 400) in 1963, he specifically mentioned the needs of the health department for computer facilities. The Honeywell 400 was installed in 1965 and it was indicated that it would be about 18 months later that sufficient time would become available to the health department for it to undertake its own programmes. A survey was therefore undertaken in the health department to see which were the most suitable applications for the department to adopt, as a result of which it was decided that the vaccination and immunisation programme would be the first application. This programme was chosen for three reasons:

First: The West Riding County Council had adopted in July, 1964 a policy which was designed to encourage co-operation between family doctors and the West Riding Health Department. This was to include the publication of a bulletin, the attachment of health visiting and nursing staff to general practices and the sharing of accommodation both in existing clinics and in purpose-built health centres. It was quite obvious in 1965 that while this policy would have a great impact on general practice in the West Riding, even so a successful vaccination and immunisation scheme would affect a larger number of general practitioners and a greater proportion of the population than the other portions of the policy.

Second: The immunisation rate for infants was approximately 75 per cent. varying slightly from year to year. This meant that three children in every four had completed a primary course of immunisation by the end of the second year of life. It was known that some areas of the county had very high immunisation rates but in other areas of the county the response was low; such variations were seen also within West Riding divisions, some townships having an excellent record and others being poor. These differences occurred in spite of detailed and devoted work by staff involved. With the declining incidence of diseases like diphtheria, it was even more important to ensure that every child was given the opportunity of being immunised. We also received encouragement from the remarkable success of the West Sussex County Health Department which had then raised the immunisation rates there to over 90 per cent.

Third: Since the vaccination and immunisation programme started from the birth notifications, it might eventually become the basis for a comprehensive child health record.

The objectives of the scheme could therefore be stated to be the improvement of co-operation between two arms of the National Health Service in the West Riding; the raising of the immunisation rate; and the extension of the existing child health records.

Developing the System:

A small programming team was set up between the County Treasurer's Department and the County Health Department and we were very fortunate at this stage in obtaining the services of Dr. Irene Whitwam (now Dr. Irene Hazelton) who had had considerable experience of computer work at the Western Reserve University, Cleveland, Ohio: some of the unique features of the West Riding scheme owe much to her foresight and expertise.

Two pilot areas were selected; the Municipal Borough of Keighley (Division 3) and the Wortley Division (Division 22) on the northern border of Sheffield. Both were chosen because of their distances from County Hall, since one of the important elements in the computer scheme would be the reliability of the postal service. In addition they were very different, one being compact and the other being much more scattered in character. The registration of children on the computer began on 1st January, 1967, and by the middle of the year it was apparent that the scheme was likely to meet with considerable success. Of the children registered on the computer, 552 could have completed a primary course by the end of August, 1967; 411 (74.5 per cent.) had completed a primary course and 107 (19.1 per cent.) had partly completed a primary course; it was anticipated therefore that an immunisation rate of at least 90 per cent. would be achieved. The acceptability of the scheme to the general practitioners was also clear, some 60 doctors in the areas were participating in the scheme. It was therefore decided that the vaccination and immunisation system would be extended to the whole of the county, in three groups of divisions during 1968. These were as follows:

Group	Date for beginning the recording of live births	Divisions
1	1st January, 1968	4, 5, 9, 13, 15, 18 & 25
2	1st April, 1968	1, 7, 10, 11, 12, 20 & 23
3	1st July, 1968	26, 27, 29 & 31

We were already committed to the extension of the scheme with the agreement of the West Riding Local Medical Committee, when the Ministry of Health (now the Department of Health and Social Security) decided (C.M.O. 9/68) to change radically the basis of the immunisation schedules. It was fortunate that the meetings held to discuss the computer system with the general practitioners in each area were only just beginning when the changes in the schedules were made and therefore throughout the briefing meetings it was possible to discuss both the computer scheme with the family doctors and also the variation in the immunisation time-table.

In the immunisation of infants there were two changes in the schedules which were important: *first*, the intervals between the doses in the primary course of triple vaccine and oral poliomyelitis vaccine were changed; and *second*, the starting date for the course was postponed to six months, but the memorandum gave some latitude about this. It was felt that the family doctors would accept the new intervals, but would have some hesitation about the starting dates. The computer programme therefore allowed for this with the triple and oral polio vaccines, while leaving the dates for smallpox vaccination unchanged. Measles vaccination was added later in 1968. The possible courses are indicated below.

Immunisation Procedure					Age of child (in months)			
Diph/Tet/Pert. and oral polio	...	...	...	...	3	4	5	6*
First dose	...	...	...	...	5	6	7	8
Second dose	...	...	...	...	11	12	13	14
Third dose	...	...	...	...
Measles vaccination	...	...	...	...	16 months			
Smallpox vaccination	...	...	...	...	18 months			

* Schedule for County Clinics

The total scheme was well received and by the end of 1968 there were some 650 practitioners who were already participating in it. While a few, mainly single handed practitioners, have withdrawn from the scheme, the number of family doctors participating has risen from 650 at the end of 1968 to 690+ at the present time. With this number of doctors participating there is, of course, a slight variation from month to month because of the change of medical personnel. These family doctors cover at least five-sevenths of the total population of the West Riding and one therefore presumes that they cover at least this proportion of the child population. The claims for their fees are passed to the Executive Council on their behalf.

The anticipated rise in the immunisation rate is also taking place. The full results for the whole county for the 1968 births will not be available until after the end of 1970. However, in the pilot areas, the rates achieved for triple vaccine and poliomyelitis immunisation were well over 90 per cent. and in the county as a whole, the results are likely to be of this order. At 31st December, 1969, 62.5 per cent. of eligible children had completed this portion of the course, and a further 29.8 per cent. were partly protected. It is therefore anticipated that the final immunisation rate will be about 90 per cent. for the whole county.

Handicapped Children:

One of the objectives in adopting the scheme was to extend the range of the present system of records. Dr. Hazelton suggested that since we were starting the system from the birth notifications, we should record at that stage the additional information given about the congenital handicaps. In addition the health department had adopted the system of the routine screening of infants round about the age of 7-10 months for hearing loss. It seemed therefore opportune for us to facilitate the testing of children's hearing by producing from the computer lists of children due for testing, and appointment cards for their parents, well in

advance of the time of testing, and to record the adverse results. These adverse results would be of two kinds: a failure of the test and a failure to take the test for some reason such as illness. An interim follow-up scheme of these adverse results was therefore devised to ensure that the children with adverse results could be retested at 18 months and yearly to 4½ years if need be. In the process of doing this we had to devise for the computer programme a system to record diagnosis of the handicaps. Unfortunately at that time the International Classification of Disease issued by the World Health Organisation was not adequate for the recording of handicap as distinct from the recording of death. In collaboration with the late Dr. Cedric Harvey, Dr. Simpson Smith devised an ad hoc classification of handicap which was suitable for our purpose. More recently the British Pædiatric Association has issued its own classification that interlocks with the International Classification of Disease: it is now possible to consider the modification of our own system in the light of this, to increase its compatibility with other computer-based handicapped children's registers. The existence of this diagnostic index makes it possible for us to record on the computer all known handicapped children. These are mainly children referred for special educational treatment and whose handicaps could be said to be of educational significance. However, this group of children contains most of the handicapped children who, as young adults, might require additional help from the Welfare Department and also consideration for placement in jobs. It seemed therefore appropriate for us to consider creating a handicap register by putting together the handicapped children recorded in infancy and also transferring some information to the computer of handicapped children of school age.

The purpose of this register will be four-fold:

- (a) To ensure that as far as possible the ascertainment of handicap was uniform throughout the county.
- (b) The co-ordination of services for the disabled child in a large county presents difficulties. It was therefore felt that a handicapped children's register would be a useful aid to administration.
- (c) The need to think ahead for the needs of disabled children as a group is paramount: and the register would give, eventually, adequate planning data.
- (d) The register could facilitate research.

Evaluation:

At the beginning these objectives were set out: how far have they been achieved?

Co-ordination: Almost 700 family doctors are using the computer vaccination and immunisation scheme. The claims for fees for these doctors for immunisation work are prepared for the West Riding Executive Council. The degree of co-ordination achieved is considerable.

Immunisation Rates: Rates of over 90 per cent. were achieved for the children born in the pilot areas in 1967. It seems probable that similar rates will be achieved for the whole county for the 1968 births.

Extension of Records: The existence of the computer birth records has formed the basis for facilitating the hearing tests in infancy and the formation of a handicapped register.

This represents a much greater measure of success than was hoped for when work on the scheme was started in 1965. Only the naive would imagine that a scheme of this size and success was achieved without difficulties. The problems arise from two main causes. It is estimated that between 1,200 and 1,300 people participate at various stages in the computer system. The data about each child is also potentially the subject of considerable variation. Both these mean that a considerable standard of accuracy is maintained only by continuing care. Many changes have been made in preparing the programmes for the new Honeywell 1250 and 2200 computers which should help all staff concerned. While the problem of accuracy is a continuing difficulty, there can be no doubt that the systems are eminently successful and worthwhile.

Acknowledgements:

The introduction of the computer system to the Health Department has been a team effort. It is a tribute to the medical, the administrative and health visiting staff that so much has been achieved so quickly. However, the special contribution of Dr. Hazelton to the initial programming, Dr. Simpson Smith to the development of the handicapped register, Mr. Ibbotson and his colleagues in the Health Department computer office deserve special praise. Dr. Leyshon is developing new applications. The County Treasurer and his staff have given valuable assistance at all stages, apart from being responsible for operating the computer. Without this co-operative effort the introduction of the computer to the work of the department would not have been possible.

DAY CARE FACILITIES FOR CHILDREN UNDER FIVE YEARS

D. E. Robertshaw, Principal Medical Officer

In June, 1969, a joint meeting of representatives of the West Riding Health and Education Committees was held to discuss the problems of day care of pre-school children in the County Area. The discussion was based on a report prepared by the Chief Education Officer and the County Medical Officer. The necessity for such discussion followed provisions made in the Health Services and Public Health Act, 1968, amending the existing legislation contained in the Nurseries and Child-Minders Regulation Act, 1948. These amendments were aimed at improving the standards of child care provided in the private sector and encouraging the establishment of increased facilities in all sectors. They also had the effect of bringing playgroups under legal supervision. Prior to this, playgroups in the County, open for less than three hours per day, had been supervised unofficially by officers of the Health and Education Departments.

Concurrent with the coming into force of the amended legislation on 1st November, 1968, the then Minister of Health issued local authorities with two Circulars for guidance on the provision of day care. The first Circular (36/68) dealt with the care of children in the private sector. Following a report on this Circular submitted to them by the County Medical Officer, the Health Committee adopted standards with which applicants for registration as child-minders or for registration of private day nursery premises (including playgroups) would be required to comply.

The second Circular (37/68) dealt with the direct provision of facilities by local health authorities for the day care of children under five years. It referred to medical and other authority opinion that, in general, early and prolonged separation from the mother is detrimental to the child and, wherever possible, the younger pre-school child should be at home with his mother, but that the needs of the older pre-school children could be met by part-time attendance at nursery schools or classes.

The Department of Health and Social Security considered accordingly that the responsibility of local health authorities should continue to be limited to arranging for the day care of children who, from a health point of view or, because of deprived or inadequate backgrounds, had special needs that otherwise could not be met. The Circulars suggested that children who may need either whole-day or part-day care would include children:

- (a) with only one parent (e.g. the unsupported mother living with her child and who must perforce go out to work);
- (b) who need temporary day care on account of the mother's illness;
- (c) whose mothers are unable to look after them adequately because they are incapable of giving young children the care they need;
- (d) for whom day care might prevent the breakdown of the mother or the break-up of the family;

- (e) whose home conditions (e.g. because of gross overcrowding) constitute a hazard to their health and welfare;
- (f) whose health and welfare are seriously affected by lack of opportunity for playing with others;
- (g) who are suffering from disabilities of body, intellect or personality likely to interfere with their normal growth, development or capacity to learn.

The two Circulars were followed up by a request from the Secretary of State for Social Services, asking local health authorities to inform him by 30th June, 1969, of the total demand for all-day or part-day care for children in the above priority groups which was not satisfactorily being met by the parents themselves.

Information was requested as to the extent to which the authority expected to be able to meet local needs in their short-term and long-term plans. The suggested categories of children in need were such that it was no easy task to make any firm reliable estimate of the number of children involved; however, the Divisional Medical Officers, in co-operation with the Divisional Education Officers, Area Children's Officers, Divisional Welfare Officers and Probation Officers, undertook surveys in their areas, and it was suggested that the following numbers should be returned to the Secretary of State as probably representing the demand not at that time being satisfactorily met by the parents themselves.

						<i>No. requiring care</i>	
						<i>Whole- day</i>	<i>Part- day</i>
(a)	Children with only one parent	...	...	...		1,100	—
(b)	Children who need temporary day care on account of the mother's illness	...	...	...	...	300	—
(c)	Children whose mothers are unable to look after them adequately	...	...	...	...	800	500
(d)	Children for whom day care might prevent the break-down of the mother or the break-up of the family	...				600	300
(e)	Children whose home conditions constitute a hazard to their health and welfare	...	...	...	...	500	200
(f)	Children whose health and welfare are seriously affected by lack of opportunity for playing with others					200	500
Totals						3,500	1,500

These figures represented a ratio of 1 child in 30 under five years living in the county area.

To comply with the Secretary of State's request as to the extent to which the Authority might expect to be able to meet local needs in both their short-term and longer-term plans, a review was made of the existing facilities for the provision of day care for children under five throughout the County. Provision included five County Council day nurseries, 25 private day nurseries, 134 child-minders and places in nursery schools and classes for 2,845 children.

The County Council's day nurseries are situated in Keighley, Shipley, Harrogate, Brighouse and Heckmondwike, and provide 220 places at the time of review. Children were admitted on health grounds only which included:

- (a) the young child whose mother was ill or having a baby;
- (b) the illegitimate child whose mother was required to work;
- (c) the young child of the widow who must educate and support her family unassisted;
- (d) the young child of the mother whose husband was ill.

In practice, category (b) was also taken to include the child whose parents were separated or divorced and where the mother was required to work.

The hours of opening of the Authority's day nurseries, namely from 8-30 a.m. to 4-30 p.m., have been criticised as not enabling mothers to take up full-time employment. However, the hours during which the nurseries remain open were determined with full regard to the interests of the children. With earlier opening and later closing, it is felt that a child might be wakened unnecessarily early in the morning and, with a later collection from the nursery it would mean the child being put to bed immediately on return home. This, together with the long absence of the child from home during the day, is not thought to be in his best interests.

Existing facilities in nursery schools and classes were as follows:

							<i>No. of places</i>	
							<i>Whole-day</i>	<i>Part-day</i>
Nursery schools	...	...	...	...	...	...	440	205
Nursery classes	...	...	...	...	...	...	2,200	

In addition, there was a small number of children who had been admitted to infant classes and primary schools before reaching the age of five.

The provision of nursery education is by no means uniform over the County as a whole, and facilities vary widely from one Divisional Executive area to another; children benefiting from this type of education are not necessarily in the priority groups. With regard to child-minders and private day nurseries, in addition to the figures already quoted, there were at 31st December, 1968, 150 playgroups

(catering for some 3,500 children) which had still to be dealt with under the new legislation so far as registration was concerned. As in the case of nursery schools and classes, the provision in the private sector varied considerably from one area of the County to another and represents a demand from parents for children to be looked after for one reason or another and bore no relation to the needs of children in priority groups.

Following the above review of the existing provisions, it was obvious that there were three ways in which increased facilities could be made available: the provision of more day nurseries, more nursery schools and classes, and by making use of the child-minding and day nursery facilities provided in the private sector. With regard to day nurseries, the provision of additional day nurseries in the south of the County, where no such facilities exist at present, would be a valuable contribution towards meeting the needs of children in the priority groups. It was not considered that more than a few day nurseries would be required, as, if they are to be economic units with 40 or 50 places, they need to be sited in the more populous areas where there is a sufficient number of children in the priority groups within a small radius of the nursery. Regard would also have to be made to the possible provision by the Education Committee of additional nursery schools and classes.

Circular 37/68 stated that the Secretary of State would continue to recommend loan sanction for day nursery projects where a majority of the children for whom they were intended are in need of special care, but the available capital investment was such that only a proportion of such schemes could be approved for the three-year period from April, 1968.

The Education Committee, having considered the provision of nursery schools and classes, had submitted 33 proposals to the Department of Education and Science for help under the terms of the Urban Aid Programme; these included the establishment of nursery units, help to pre-school playgroup associations towards the expenses of establishing pre-school playgroups, and language classes for immigrants in certain areas. In addition to these proposals, the Chief Education Officer intended to seek approval for the appointment of an adviser for nursery classes and playgroups following joint discussions with the officers of Health Department and members of the Yorkshire Association of Pre-school Playgroups.

Child-minders and private day nursery provision could also be used by the Health Committee to provide facilities for all-day or part-day care for individual children in the priority classes. Such groups should be used by placing children on agreed terms with carefully selected child-minders or in playgroups giving a high standard of care.

Discussion of the report was followed by recommendations suggesting:

(1) that the categories of children for admission to the Authority's existing day nurseries should be amended to accord with the priority groups suggested in Circular 37/68;

- (2) that approval be given in principle to the provision of additional day nurseries in areas where the Committee deem this to be necessary;
- (3) that children in the priority groups to be placed with selected child-minders or in private day nurseries on agreed terms;
- (4) that approval in principle be given to the granting of financial aid in selected cases where it is considered necessary to encourage the establishment of private day nurseries to meet the needs of children in the priority groups.

These recommendations were approved and subsequently a more detailed survey was made into the needs of children in the different areas of the County. At the beginning of November, 1969, it was estimated that 965 children would benefit from some form of part-time care and 2,434 from full-time care. It had been decided that provision of day nurseries would only fill the needs of some of the children in the priority groups and that in many instances a large catchment area and relatively-small numbers made day nursery provision unsuitable. Placement in playgroups or with selected child-minders was considered to be best in these cases. The Health Committee, therefore, approved a request—

- (1) to the building of two day nurseries in the south of the County, and
- (2) to the Authority arranging and paying for children in the priority groups to receive day care by selected child-minders or in nurseries or playgroups run by private or voluntary bodies.

At the end of December, the number of private premises registered for providing day care for children was 179, providing full-day care for 234 children and sessional care for 4,073 children. Persons registered as providing care for children under five numbered 252, providing full-day care for 664 and sessional care for 339 children.

The Education Authority had received approval by the Department of Education and Science for nine of their proposals submitted under the Urban Aid Programme. These include the provision for 12 new nursery classes which would offer 210 places. The Home Office authorised additional projects which included the provision of aid to the Pre-school Playgroups Association and assistance has been arranged in five Divisions of the County. A nursery schools adviser has also been appointed and is working in the south of the County.

THE PULSE QUICKENS

HOME NURSING SERVICE

This paper was written by Miss N. I. Harris, Deputy County Nursing Officer, as part of the Nursing Administration Course held at the Royal College of Nursing, 21st April to 11th July, 1969, at which her attendance was authorised by the Health Committee. A shorter version is also to appear in the department's own publication *Health Notes* which is circulated to all general medical practitioners.

It seeks to consider the Home Nursing Service in the West Riding of Yorkshire, look briefly at the reasons for the declining case load from 1956-62, and examine in more detail how the situation has been reversed.

The County of the West Riding of Yorkshire covers 1,606,499 acres, comprising 13 municipal boroughs, 55 urban districts and 21 rural districts. The estimated mid-1968 population was 1,774,270.

The Home Nursing establishment from 1962 to October 1st, 1968, was 290 whole-time nurses. With the approval of the County Council, the establishment was increased on October 1st, 1968, by six whole-time nurses to 296. A further increase of six whole-time nurses on April 1st, 1969, was unfortunately deferred because of the need for further economies in County spending.

The intention of the National Health Service Act, 1946, was to "Promote the establishment of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness." To provide a truly comprehensive service, designed to meet all the needs of every type of patient in the most effective way, calls for both co-operation and co-ordination of the highest order.

During the last seven years, three reports (i.e. *A Hospital Plan for England and Wales*, *Health and Welfare: The Development of Community Care* and *The Field and Work of the Family Doctor*) have drawn attention to the need for co-operation amongst the three branches of the service and, in particular, the recognition of the important position of the family doctor.

A Declining Case Load 1956-1962:

The steadily-decreasing case load was, to some extent, due to the increase of oral drug therapy and the consequent reduction in the number of cases and visits. Not only was the number of injections decreasing but there was a steady decrease in other spheres of work. The Home Nursing Service appeared to be

going through a period of depression. Staff were bound by tradition; they lacked enthusiasm and were ready to delegate almost the whole content of their work to lesser-trained staff; they seemed bored and appeared to obtain little satisfaction from their work. The general practitioners were not using the home nurses to the full, and appeared unable to appreciate their value. Home nursing in this kind of intellectual climate is entirely unsatisfactory. The publication of reports already mentioned sought to suggest remedies. The most marked and common theme of the three reports, however, is the insistence on the need for co-operation amongst the three branches of the service.

The continuing downward trend in the amount of work undertaken by the home nursing staff was viewed with some concern and, in 1963, Dr. P. H. Brewin undertook a survey which sought to assess the content of the home nurses' work. Considerable disquiet was felt about the findings of this survey, and it was obvious that the activities of the Home Nursing Service needed careful attention. It is interesting to note that the findings of the report *Feeling the Pulse*, undertaken in 1965 by Miss L. Hockey, did bear out the findings made two years earlier by Dr. Brewin. It was found that the average working day of a home nurse in the West Riding was six hours, which compared with areas 'A' and 'F' in *Feeling the Pulse*. It would appear from these and subsequent surveys that this was a national trend and that the case load was falling throughout the country. (See Graph 2).

'The Pulse Quickens'—1962-1968:

It is thought that the following factors have contributed towards the continued increasing case load:

- (1) Implementation of County Policy.
- (2) Use of disposable equipment.
- (3) Training of staff.
- (4) Improved records.
- (5) Support of local health authority services.

IMPLEMENTATION OF COUNTY POLICY:

Future Developments in the Health Service and Co-operation with General Practitioners—Dr. R. W. Elliott, 1964.

In this report, approved by the County Council of the West Riding of Yorkshire, developments are outlined which, when implemented, are designed as part of a policy of improving the community health services. The report outlines measures of co-operation with general practitioners, making available to them:

- (a) Surgery premises to be provided in clinics and, where desired, in health centres, either existing or to be built, at negotiated rentals.

- (b) Clinic premises for their own antenatal, postnatal and infant welfare clinics; subject to the premises being available at mutually-agreed times, these facilities are offered free of charge.
- (c) The supporting services of the health visitor, home nurse and midwife by attachment to practices in either a whole or part-time capacity.

The implementation of this report has undoubtedly made a tremendous impact on the Home Nursing Service. Regarding the Home Nursing Service Dr. Elliott said in this report, "The home nurse at present works under the clinical direction of the general practitioner, who is unaware of her commitments to his colleagues in the area or of the relative importance of her work, and may be dissuaded from referring cases for her attention under the erroneous impression that she is fully occupied. This situation is particularly likely to arise immediately following a period of staff difficulty due to sickness, resignations, and retirements; it will not arise if the home nurse is wholly attached to general practice of sufficient size, since the practitioner will be fully aware of the extent of her duties and can thus deploy her services as may be required. It will, therefore, be the aim to make such attachments wherever possible." Concluding the report, Dr. Elliott said, "An acceptance of this policy will not lead to an overnight revolution and many years of patient negotiation and implementation are to be expected before the ultimate purpose is achieved."

I have quoted at length from this report because of its importance in directing all thinking and planning from 1964 to the present time.

Attachment of Home Nurses to General Practice:

Much has been written on the attachment of staff to general practice, and the importance of careful and detailed planning before the attachment is actually effected is now widely realised. An attachment scheme that really works can only be the result of patient negotiation and planning. Much of the careful planning and negotiation in the West Riding was undertaken by the County Nursing Officer in post at the time and the Divisional Medical and Nursing Officers. The staff were informed of the current thinking and planning, and they were given every opportunity to discuss their problems, raise their objections, and pass their comments. Their problems, objections and comments were considered sympathetically; and so, patient and careful negotiation continued. Proposals, plans and policy had to be discussed with the general practitioners when they requested attachment of staff. Administrative difficulties seemed almost overwhelming at times, particularly in the early days; but, with goodwill, most difficulties were overcome.

The attachment of home nurses to general practice progressed slowly at first, but it has steadily gathered momentum. (See Table I).

On December 31st, 1968, 196 of the 296 home nurses were attached to general practice. It must, however, be realised that, to give a continuing service, relief nurses must be used, as the work of an attached nurse cannot be handed over to another attached nurse in the case of sickness, holiday, etc. If this occurred, the inevitable cutting down of work would ensue. In the West Riding, approximately 50 nurses are used for relief duties and they also visit patients whose doctors mainly practice in county boroughs. The West Riding geographical area has 10 county boroughs within its boundaries and administrative difficulties do arise in the areas surrounding the large county boroughs such as Leeds and Bradford, but here again, with patient and careful planning, the difficulties can be minimised.

Adequate relief must also be made available in the case of maternity leave, long-term sickness, and where a nurse is undertaking district training. It is necessary, in this situation, to appoint temporary staff (either whole or part-time) to fill the vacancy and it has been found absolutely essential to have enough spare home nursing establishment available, centrally, to make these temporary appointments possible. If this is not done, practices could be left without staff for long periods and, naturally, the work load decreases and the patient does not receive the needed care.

EFFECTS OF ATTACHMENTS:

Where nurses are attached to general practitioners, there is a better continuity of care and co-ordination about their work. The Royal College of General Practitioners, in the June, 1968, issue of its journal, comments on the fact that papers have proved that attachment has led to more co-operation with colleagues. There is a better marshalling of various social aids and an increased range of the amount of work done by nursing staff, as well as removing the irritating duplication of services and advice which was previously quite common. It is obvious that the rôle of the attached nurse has changed but that finality has by no means been reached regarding her duties. An experiment in Bristol in 1967 found that, apart from greater job satisfaction and improved communications, there was a marked increase in the amount of work undertaken by home nurses attached to general practice.

There has been a considerable increase in the home nurses' work in the West Riding Administrative Area since 1964 (see graph 1) when the policy of attachment of nursing staff was implemented, and here the importance of regular visits to the surgery cannot be over-emphasised. Attachment without regular communications will not result in an increase of work. Attachment of nursing staff to general practice does affect the amount and type of work undertaken. These changes do not always occur in the early stages of attachment, but some change in the work pattern can usually be seen within 9-14 months; undoubtedly, without attachment, changes do not occur. (See Tables II and III).

As increasing numbers of home nurses are attached to general practice, the number of cases referred by general practitioners rises. (See Table IV).

These figures only refer to work undertaken in the patients' homes. Many of the attached nurses are undertaking treatment sessions run by appointment in the doctor's surgery, and the amount of surgery work is increasing. This paper will not deal in detail with this aspect of the work, as papers have already been published on this matter, but rather will show that the content of the home nurse's work can be changed and that the work undertaken in the domiciliary field does present a challenging and rewarding sphere of service.

THE HOME NURSE AND ATTACHMENT:

The first six months of an attachment can be difficult and, during this time, the home nurse needs the support and guidance of her nursing officer. One has to appreciate that, in nearly every practice, a system has been evolved and staff employed to meet the demands made on the practice, and the introduction of a new member of that team, who is not directly employed by them, can be disturbing. A great deal of liaison and understanding is required before a completely compatible situation can be attained.

For example, a home nurse was attached to a large practice in a very urbanised area (a practice that should have been able to keep at least two nurses fully occupied) and this practice was referring only terminal cases, enemas and the inevitable bed baths. Total visits for one month amounted to 150 instead of at least 600. The general practitioners had to be made aware of the capabilities and potential of the attached nurse and, in this particular instance, as a result of discussing the need for more work with the doctors concerned, a new way of working was evolved. The nurse began to learn more of case histories, diagnosis and treatment; reports and treatments were discussed, and all possible ways of helping the patient considered. Surgery sessions were undertaken; patients who would normally require a visit at home but were able to visit the surgery, were treated, these treatments including dressings, injections, ear syringing, and cases previously referred to the hospital casualty department. Some routine screening was also undertaken, blood pressures and weights recorded, and urine tests undertaken—particularly in the case of recurrent septic lesions and hypertensive disease. Obviously, careful management of case lists is essential where the list is extended to accommodate surgery sessions. Techniques are developed whereby cases are fully discussed and the work adapted to suit the patient and make best use of the services available. Whilst the work load includes a relatively small nucleus of chronic sick (approximately 30 patients), the majority of work is more acute. Patients previously admitted to hospital are nursed at home. The use of oxygen and B.D. drug therapy have enabled acute bronchitics to remain at home, only being admitted to hospital in extreme cases or because of overwhelming social conditions. More terminal cases are also nursed at home. In addition, the following show a changing pattern of work:

- (1) Rehabilitation of patients by making greater use of equipment available and by creating an interest in physiotherapy.
- (2) Increased use of short-stay facilities in the local geriatric hospitals.

- (3) Increased visits to the elderly; supervision of treatment, particularly in the administration of oral antibiotics and diuretics; support and advice given.
- (4) Increased co-operation with local hospitals, particularly where patients are attending as outpatients; reports sent with the patient for the information of the consultant.
- (5) Preparation of patients for, and attendance at, consultant's domiciliary visits.
- (6) Post-operative follow-up of patients in lieu of doctor's visits.
- (7) Routine calls following diagnosis by the doctor, i.e. infectious diseases. (Number of visits in West Riding Administrative Area have risen from 473 in 1962 to 3,397 in 1968).
- (8) Education of relatives.

Changes have also occurred in the more routine work, i.e. surgical cases have risen from 6,012 in 1962 to 9,240 in 1968; medical cases have risen from 20,054 in 1962 to 26,484 in 1968.

A close co-operation and a willingness to share and accept the various tasks required to assist the general practitioner in the care of his patients—a co-operation not only between the doctor and the nurse but also the health visitor and surgery staff—are necessary.

The need for home nurses to widen their range of work is appreciated, and administrators must accept the necessity for an expansion of visits where 'nursing treatment' in a traditional sense cannot be classified. The needs of the bereaved, the support of relatives, the supervision of oral therapy in the elderly, the advice to the chronic sick and the patient suffering from malignant disease need the home nurse's expertise. In the West Riding, cases classified as 'Others' have risen from 572 in 1962 to 3,078 in 1968. The nurse of to-day should, in fact, no longer see her rôle as containing illness and of maintaining a status quo. Perhaps her most vital activities are in the field of rehabilitation, education, and—increasingly—of mental health. In all these spheres, she is in a position to make a unique contribution; because she offers practical help and comfort, she has little difficulty in securing trust and acceptance from her patients, and, through her particular skills and qualities, she can turn this trust and acceptance to practical use in order to help them. This is a relationship calling for patience and love, and demanding judgment and social skill. It is also a relationship immensely rewarding and socially valuable.

“Seconding nurses to general practice by local authorities will prove to be the greatest single factor in improving community care throughout the country. If those who partake increase their job satisfaction by working this way, the one that really matters will benefit most of all.”

Health Centres:

Within the last few years, this programme has developed rapidly following the initial step of creating Cleckheaton Health Centre in 1964. Subsequent development on the lines of shared accommodation has been quite considerable. The extensive building programme has obviously made working together easier. Health visitors, home nurses and midwives are working from 86 purpose-built centres, 53 adapted buildings and 103 rented premises. The buildings and the policy of attachment have brought the nursing team together so that they can now give a united service. It is most refreshing to see the interchange of opinions and ideas between health visitors and home nurses.

USE OF DISPOSABLE EQUIPMENT:

A Working Party was set up in 1963 to look into the home nurses' uniform and equipment and the equipment used to assist in the care and after-care of patients. The result of this Working Party was that the County Council's Health Committee approved the changes recommended by the Working Party and the content of the nurse's bag was replaced by much disposable equipment. All necessary nursing aids for the patient became readily available.

TRAINING OF STAFF:

District Nurse Training:

Until 1962, the whole content of the training of home nurses had been undertaken in two adjacent county boroughs, the nurses being seconded for the whole of their training period. This secondment obviously presented problems, particularly for the married staff with children who could not leave their families for four months. In 1962, arrangements were made for the practical content of the course to be undertaken within the County area and for the students to undertake the three weeks' theoretical training period at the district training centre in one of two adjacent county boroughs. Senior nurses were appointed and were responsible, with the Divisional Nursing Officers, for the practical training of students. The student district nurses received their practical training away from their 'home areas' and were treated as students and not as 'another pair of hands'. They were seconded for training on full salary and were under contract to the Authority for twice the length of the training period. The result of this was that all nurses could undertake training without too much difficulty.

With the withdrawal of the Queen's Institute of District Nursing from the overall responsibility for training and examination of students, the whole content of district nurse training was, from May, 1968,—with the approval of the Department of Health and Social Security—undertaken by the County Council. (114 nurses have undertaken the district training course since 1962).

Two courses for West Riding staff are held each year, with ten places on each course, and it has been found that, by training 20 nurses each year, new appointments can usually be accepted for a course within six months of taking up their appointment as home nurse. All nurses applying for home nursing posts in the West Riding must agree to undertake the district training course.

The importance of this training programme is considerable, and a wide interpretation of the syllabus is essential—with regular changes to keep ahead of developing trends. Training is no longer a confined practical training in nursing techniques but a comprehensive, interesting and intellectual approach to the total care of the patient. Nursing care of patients in the community must be of the highest quality and, to achieve this, it is essential that all nurses who give this care should receive appropriate training.

In-Service Training—West Riding Staff College, Grantley Hall, Ripon:

A special seven-day residential course on 'Rehabilitation' was arranged, with the help of the physiotherapists from the Royal Bath Hospital, Harrogate, for the home nurses. This course was repeated each year for five years, thus giving all the home nursing staff an opportunity to attend. The course proved extremely helpful, as it gave the nurses the practical knowledge they needed to assist them in their work of rehabilitating patients. Some indication of the value of these courses may be seen in the fact that loans of walking aids increased from 515 to 2,050 in five years.

The usual programme of group lectures, films, and staff meetings has continued in the Divisions.

IMPROVED RECORDS:

All records used by the home nurses were reviewed and a standard card was introduced in 1962. This card, when completed, contains all the necessary information regarding a particular patient as well as a complete record of all visits.

SUPPORT OF LOCAL AUTHORITY HEALTH AND WELFARE SERVICES:

"A medical care system should keep institutional care to a minimum and thus respect the individual's need to be with his family."

If hospital authorities are prepared to discharge their patients as quickly as possible and general practitioners refer increasing numbers of patients to the home nursing service, the local authority health and welfare services must give the necessary support. With 90 per cent. of illness treated at home and illness producing the need for care of the patient, support of the family, and supportive services, the importance of these services is considerable. The home nurse not only needs to have a working knowledge of the supporting services but these services should be readily available when needed.

Nursing Equipment:

The need of bed pans, mackintoshes, and backrests was realised in the past, but the needs of to-day must include, in addition, hydraulic hoists, ripple beds, sheepskin and man-made fibre pads, incontinence pads and pants, an efficient

laundry service, and a wide variety of rehabilitative equipment. Home nursing is not a 'cottage industry' and the needs of an efficient service demand a high quality of nursing aids.

Domestic Help Service:

The availability of adequate domestic help obviously reinforces the effectiveness of patient care in the home. In the West Riding, the number of domestic help hours has increased from 2,356,083 in 1963 to 2,658,451 in 1968.

Night Nursing Service:

The objects of this scheme, which is provided as an extension of the home nursing service, is to provide a night nursing service for temporary periods—usually in an emergency or during the terminal stages of illness—to afford some measure of relief to relatives who are under considerable strain resulting from caring for patients over a long period. Trained nurses, persons with nursing experience, and 'sitters-in' are employed in the service. This service is not one called upon frequently but it is one which can, nevertheless, be of immense benefit; 14,928 hours of service were given in 1968.

Welfare Services:

The provision of aids and the alteration of homes to make daily living easier for the aged and handicapped are made through the Welfare Department, with the helpful co-operation of the Welfare Officer. Wardens' Schemes for the aged have also developed in the past years, not only making provision for the elderly living in council property but for aged persons living in privately-owned or rented property. A total of 851 such schemes has been approved by the County Council. Short-stay accommodation is also made available in residential homes during holiday periods. With voluntary help, the Welfare Department is also responsible for the provision of a meals on wheels service and a luncheon club service. In 1968, 434,270 and 46,414 meals respectively were provided by these two services. Integrated clubs have developed throughout the County, making further provisions for the handicapped.

Housing Authorities:

The imaginative and practical building of many units of accommodation for the elderly has resulted in many more aged persons being able to exist alone in easy-to-manage flats, bed-sitting rooms and bungalows, with labour-saving devices (such as washing machines and dryers) being available at central points. The clearance of much substandard housing has also made the care of the patient very much easier.

Other Services:

Increasingly, the nurses have contact with public health inspectors and mental welfare officers as problems are discussed. A comprehensive chiropody service is also provided.

The report *Care in the Balance* found that the Home Nursing Service played a minimal part in the care of patients discharged from hospitals. In 78 per cent. of cases, no indication of any request for community services was given. With the attachment of nurses to general practice, great improvement in the total care of the patient has ensued, but, without the co-ordination of all three services, the full benefit of an effective service cannot be appreciated. With more and more emphasis on community care, the Home Nursing Service should be used as a desirable alternative to hospital care and to provide planned continuity of care. The centre of care will, in the future, increasingly be in the community and the future for the Home Nursing Service is most exciting and challenging. The need for the total care of the ill patient in his own home is still the home nurse's most important field of work, and, whilst surgery work is valuable, attachment should bring about an increasing amount and range of domiciliary nursing care. For economic, professional and psychological reasons, the community services must be prepared to accept the care of all patients whose medical condition permits their home care, and the Home Nursing Service must play its part. It can only do this if there is sufficient staff, suitably deployed, and all workers concerned with any aspect of community care are willing to make a combined effort to work together.

In conclusion, I quote again Dr. Elliott's statement in 1964 regarding the attachment of staff to general practice. "An acceptance of this policy will not lead to an overnight revolution, and many years of patient negotiation and implementation are to be expected before the ultimate purpose is achieved." These words were true then and are, perhaps, even more true to-day; the ultimate purpose has not yet been achieved in the whole County but a start has been made. Changes appear inevitable in the structure of the Health Service and any administrative change at national level is bound to be a lengthy and—possibly—a painful process. It is vital that there should continue to be concentrated efforts throughout the country to increase still further the unification of the services, irrespective of any future plans on a national scale. What is most important is an effective partnership between the services at local level.

"There must be a beginning of any good thing, but the continuing to the end until it be thoroughly finished yields the true glory . . ."

Summary:

1. The attachment of nursing staff to general practice increases—
 - (a) the amount of work;
 - (b) the range of work;
 - (c) the effective care of the patient, and
 - (d) the job satisfaction of the nurse.

2. The Home Nursing Service must have—
 - (a) carefully-selected staff;
 - (b) comprehensive training schemes;
 - (c) modern disposable equipment;
 - (d) supportive health and welfare services, and
 - (e) minimal accurate records.

3. The future requires—
 - (a) further attachment of staff;
 - (b) closer co-operation with the hospital service, and
 - (c) a continuing expansion of the service with the use of all grades of staff.

Acknowledgments:

Without the forward planning of Dr. R. W. Elliott, County Medical Officer, the support of the West Riding County Council's Health Committee, and the superb contribution from the home nurses themselves, this very encouraging situation could not have been presented.

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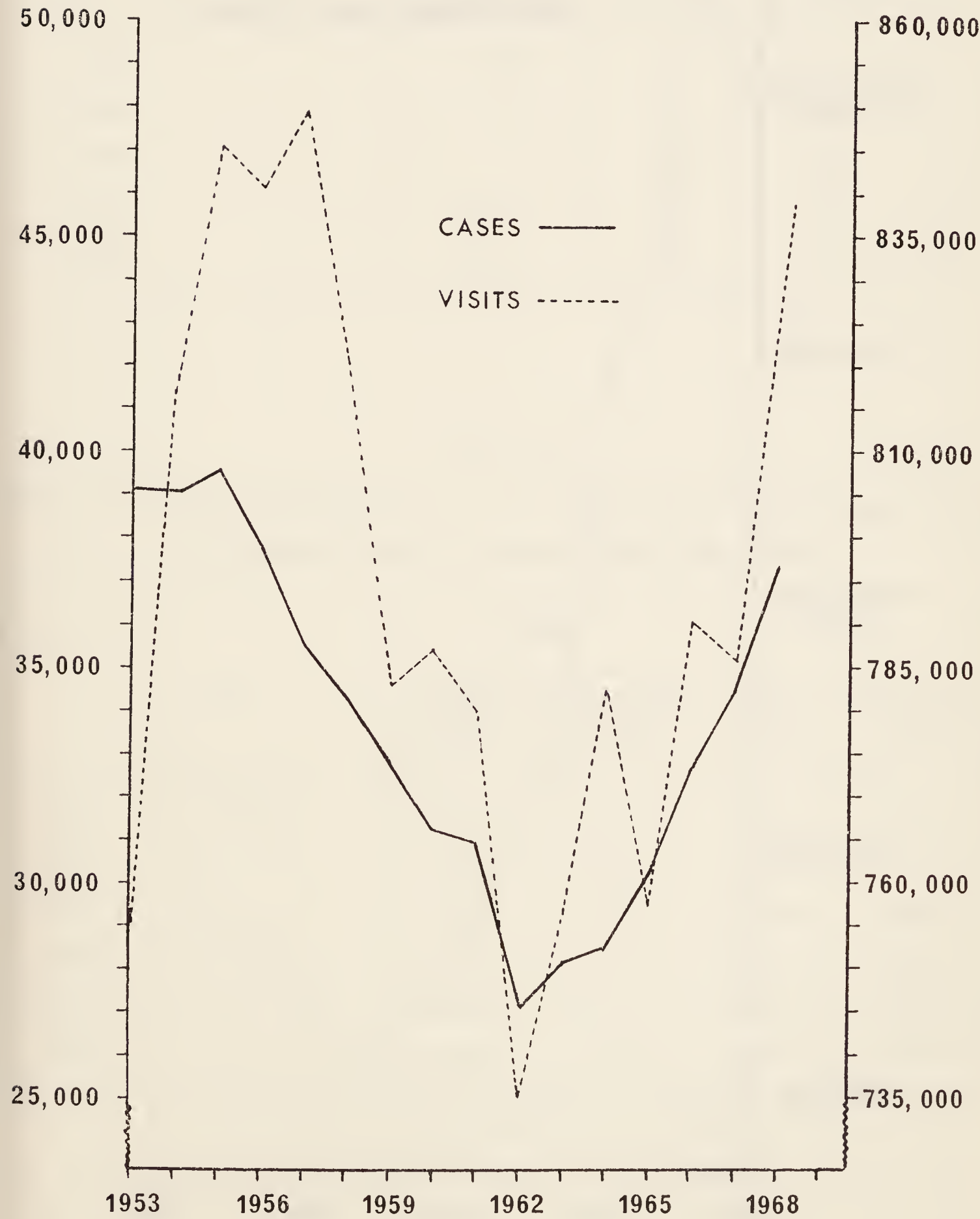
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Home Nursing Cases and Visits, 1953-68

CASES

VISITS



GRAPH 2

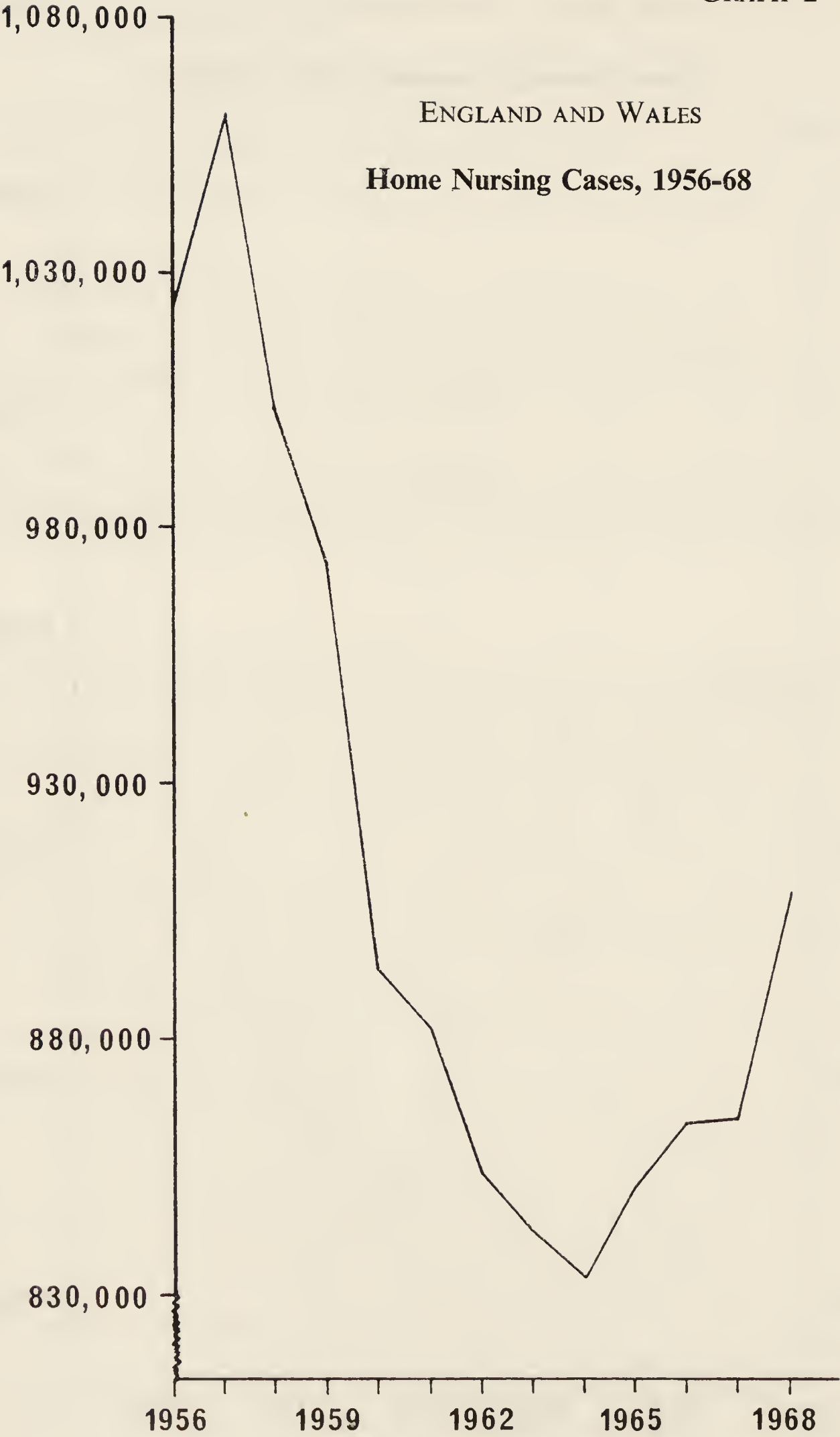


TABLE I

ATTACHMENT OF HOME NURSES TO GENERAL PRACTICE

Year	No. of home nurses attached	No. of practices	No. of general practitioners
1964	16·5	44	Not recorded
1965	47	71	156
1966	71	91	230
1967	115	165	358
1968	196	249	541

TABLE II

CASES AND VISITS UNDERTAKEN IN AN “ATTACHED” AND “UNATTACHED” AREA
(All figures reduced to work per 100 nurse weeks)

Year	CASES		VISITS	
	Attached Area (Area “A”)	Unattached Area (Area “B”)	Attached Area (Area “A”)	Unattached Area (Area “B”)
1963	244·6	197·2	6,639·2	5,947·9
1964	262·5	221·1	6,623·9	6,223·3
1965	477·8	176·6	8,927·9	4,666·0
1966	471·8	214·9	7,576·9	5,889·2
1967	608·6	216·3	8,373·6	5,876·0
1968	590·2	351·0*	8,530·1	6,290·9*

* Area “B” attached staff April 1st, 1968

TABLE III
COMPLETED CASES REFERRED BY GENERAL PRACTITIONERS
(per 100 nurse weeks)

Year	Attached Area (Area "A")	Unattached Area (Area "B")
1963	165 6	127 9
1964	181·3	152 1
1965	350 7	132 9
1966	395 4	155 9
1967	519·6	158·1
1968	527 0	283 0*

* Area "B" attached staff April 1st, 1968

Area "A" started to attach home nurses in 1964, and this was completed in 1968.

Area "B", an adjacent comparable area, attached all nurses on April 1st, 1968, and in only 9 months an increasing work load was apparent.

TABLE IV
CASES COMPLETED DURING THE YEAR REFERRED
BY GENERAL PRACTITIONERS

Year	No. of cases referred	No. of nurses attached
1962	15,374	—
1963	16,606	—
1964	16,520	16 5
1965	17,332	47
1966	19,704	71
1967	20,033	115
1968	23,637	196

TABLE V

CLASSIFICATION OF DISEASES

COMPLETED CASES ONLY

SOME OF THE DISEASE CLASSIFICATIONS SHOWING AN INTERESTING INCREASE

Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1962	122	1,369	67	1,394	1,471	351	326	393	425	1,752	1,376	424	554	1,260	990	392
1964	203	1,498	49	1,600	1,412	352	365	459	602	1,745	1,594	513	570	1,349	1,001	381
1966	324	1,679	137	1,938	1,655	473	500	641	658	2,269	1,777	693	695	1,827	1,200	715
1968	492	1,900	130	2,299	1,616	619	800	860	769	2,401	2,148	824	926	2,589	1,322	732

1. Other infectious diseases

2. Malignant and lymphatic neoplasms

3. Asthma

4. Anæmias

5. Vascular lesions affecting the central nervous system

6. Other mental and nervous diseases

7. Diseases of the ear

8. Diseases of veins

9. Upper respiratory disease

10. Other respiratory disease

11. Other diseases of the digestive system

12. Complications of pregnancy and puerperium

13. Diseases of joints, bones and muscles

14. Injuries

15. Other defined and ill-defined diseases

16. Diseases not specified

RENAL DIALYSIS AT HOME

G. E. Leyshon, Principal Medical Officer

Major advances have been made in the treatment of chronic renal disease in the past decade. Two of these advances, chronic renal dialysis and renal transplantation, are outstanding in so far as they provide treatment for a condition which was always fatal in the past. Renal dialysis by the artificial kidney was first used as a life saving procedure in acute renal failure; the aim was to keep the patient alive until the damaged kidneys recovered; if this did not happen within a matter of weeks then the outlook was poor. Equipment in those early days was bulky but technical achievements have reduced the size of the artificial kidney so that it can now fit alongside the bed in a small room. Even so technologists are working on smaller, safer, more efficient artificial kidneys, and disposable units are likely to be available soon. This simplification and reduction in the size of the artificial kidney has now made it possible for renal dialysis to be carried out for much longer periods and in a patient's own home.

As technology has advanced, so has medicine, especially renal physiology and biochemistry. The value of surgery should not be under-estimated, diseased kidneys may be removed and healthy ones transplanted; minor surgery is also vital to the patient, like the good arterial-venous shunts which now make long-term renal dialysis possible. Technically renal dialysis may be offered to all suitable patients suffering from chronic renal disease.

An approximate estimate of the number requiring treatment is about 50 people per million or about 180 cases per year for the West Riding geographical county; but the actual number receiving dialysis in England and Wales in June, 1969 was 679 of whom 289 were on home dialysis. There is therefore a long way to go before all those who could benefit receive treatment.

In Yorkshire there are hospital units for renal dialysis at Leeds, Sheffield and Hull. A unit of ten beds will theoretically provide treatment for 100 patients but experience has shown that this is more likely to be 30 per unit. This will depend on patients progressing to home renal dialysis and thus freeing valuable hospital beds. The local authority under Section 12 of the Health Services and Public Health Act, 1968, is empowered to carry out adaptations to the home to enable a patient to undergo renal dialysis. The cost may be reclaimed from the patient but in none of the West Riding cases so far has this been done. Even so, it is expensive to treat cases of chronic renal failure at home: first there is the cost of adaptation which is on average about £350; secondly the equipment costs £2,500; and thirdly the annual running costs of about £1,500 per year. The dialysis equipment, the fitting of a telephone and the annual running costs are paid by the hospital.

The great advantage of home dialysis is the reduced cost to the community as a whole, estimated to be half that of treatment in hospital. A hospital bed is also freed for another patient. Less obvious is the improvement in the patient's

health. A patient on home dialysis can undergo treatment at a time which is convenient for him, rather than having to fit into a tight hospital schedule. He can undergo dialysis three times a week rather than twice as in many busy hospital units. Dialysis can take place at night, so that the person can be free to continue employment during the day. Even should there be a machine failure dialysis can be stopped until the fault is corrected, then dialysis resumed for the full time or postponed until the following night. The principal medical advantage however, is the decreased risk of infection.

Infection at the shunt site is serious; it may lead to thrombosis necessitating further surgery for insertion of a new shunt, or it can lead to septicæmia. But the infection that renal dialysis units fear most is serum hepatitis which could close down a unit, and of which there is little or no danger at home. Finally there is the psychological benefit to the patient of being at home with his family and leading a more normal life.

Selection of Patients:

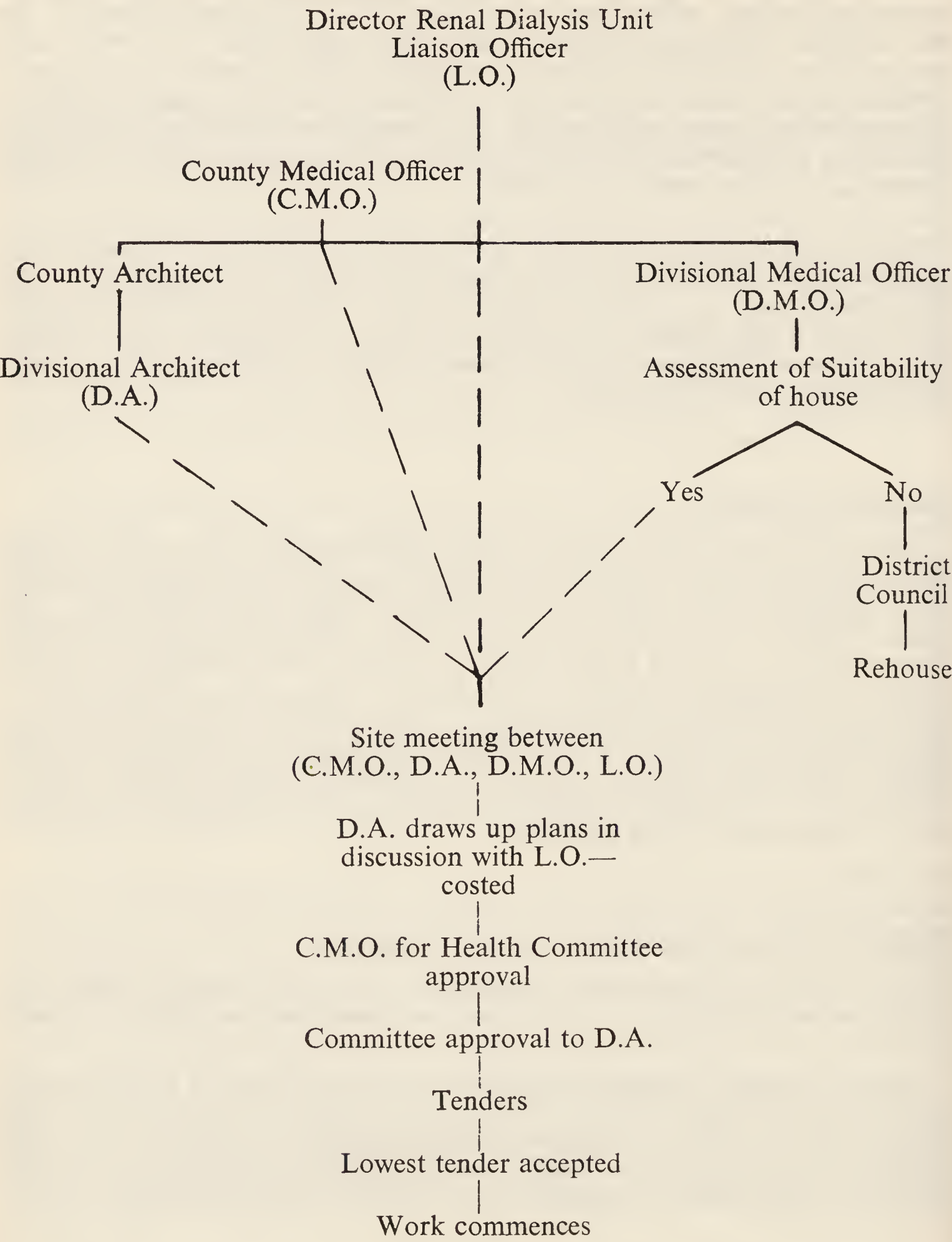
Much has been written in the lay press of this highly emotive issue, but the dilemma which doctors feared has not arisen in practice. Decisions are made on medical grounds only; often it is a question of 'first come, first served'. The main criteria for acceptance on to the chronic dialysis programme is that the disease must be confined to the kidneys, that there is no permanent secondary effects on the heart or the circulation, and no other serious disease such as cancer. The patient must agree to and be able to undertake home dialysis. For this, the doctor must have a knowledge of the home background and of the family. Although ideally a psychiatric assessment should be made, this is impracticable because at the time of admission to the programme, the person may be desperately ill and depressed.

Referral Procedure from Hospital to Local Authority:

In a county as large as the West Riding it is essential to have co-ordination of the services so that the work of adaptation is completed as quickly as possible.

When the patient is ready for transfer to dialysis at home, it is vital that the house should be ready for him. The longer the delay between the patient being ready and the adaption of the house being finished, the greater the fall in the patient's morale; if it is too long it may be difficult for the patient to break from the security that he wrongly believes only the hospital can give.

The procedure adopted in the West Riding is shown below. Each renal dialysis unit has appointed a liaison officer who is responsible for the administrative procedures.



The procedure is complicated and liable to delays. The main delay in practice has been with rehousing in spite of the district councils having given top priority to renal dialysis cases. Even though there is the greatest goodwill, many districts do not have enough four-bedroomed houses available.

Cases dealt with in the West Riding:

Total referred	22
Died prior to starting adaptations	3
Transplant prior to starting adaptation	1
Deferred pending further treatment	2
Adaptations completed	12
Adaptations in progress	4

Of the cases for whom adaptations were completed, one has since had a transplant and another has died from a gynæcological illness unconnected with the renal condition. The remainder are doing well. Sixteen cases were referred from Leeds Regional Hospital Board and six from Sheffield. There were thirteen men and nine women. The cost of adaptations varied from £270-£585, with an average of £377. The time of completion was longer than expected, ranging from four to eleven months. The first six adaptations averaged nine months, but the last six are taking only five months on average, with the latest ones being completed in under four months; it is apparent that the reasons for the long delay in the early adaptations have now been overcome.

Requirements:

First, the house has to be large enough to have a room solely for dialysis. A couple with a family will need at least a three-bedroomed house. The dialysing room need not necessarily be upstairs, in fact it is easier if it is a downstairs room because of such problems as water pressure and drainage. Most families however prefer an upstairs room to be used. The room has to have a minimum floor area of 100sq. ft., i.e. a room 10ft. x 10ft. or 12ft. x 9ft. This usually excludes the third bedroom of an ordinary council house, or indeed many owner-occupied houses. The room will need to accommodate the dialyser machine, the kidney unit, a weighing bed, or a hospital bed with a weighing machine. There has to be room for a water softener, a locked medicine cabinet, and a telephone. Further points to be considered when selecting a room for dialysis are the proximity of the water supply and of the drains; there is, therefore, an advantage in having the room next to the bathroom. The floor has to be strong, because the weight of the equipment when filled with water is over 500lb.

There must also be:

- (i) A sink unit with a draining board. This should be bigger than the standard kitchen unit. There must be a hot and cold water supply with a mixer tap. The sink unit is necessary for the preparation work prior to the patient's treatment, scrubbing for sterile procedures and cleaning of the medical equipment after treatment.
- (ii) Drainage for the sink and medical equipment.
- (iii) Cold water supply for the dialyser machine, in addition to the water supply to sink unit.

- (iv) At least three electric power points for medical equipment and sundry items.
- (v) Good general lighting, usually a strip light above the bed and a table lamp at the side.
- (vi) Shelving for storage of bottles for dialysis fluids etc.
- (vii) Patient/attendant alarm system. (Usually the spouse will sleep in another bedroom which would be connected with an alarm system to the patient's bedroom).
- (viii) The floor also needs to be covered with a waterproof covering, the edges of which should be curled up to stop leakages.
- (ix) A minimum temperature of 65°F must be maintained so that a heater may need to be installed.

Future Programme:

The West Riding Health Committee have authorised the purchase of portable cabins for use in future dialysis cases. These have the advantage that they can be ready for use in under two months; they avoid the need for structural alterations to a patient's home; if the patient is given a kidney transplant, moves house, or dies, the cabins can be transferred to other patients. The County Architect has agreed a basic design with the manufacturer and the hospital; the cost is approximately £850 including transport, preparation of site, and connection of services.

Supportive Role of Domiciliary Health Team:

Patients on home renal dialysis are unique in many ways not least of which is the fact that although in the community they remain principally under the care of the hospital services, and a patient in distress will turn not to his own doctor nor to the domiciliary services, but to the hospital. There is every justification for this, for unless a family doctor or district nurse has undertaken special training, then they will be at a disadvantage in dealing with a technically competent patient.

Although in the emergency situation the domiciliary services may seem to have little to offer, they can do much in long-term support. These families are under strain, they may be chronically fatigued and depressed; they are unable to escape from their commitment. There may be inter-personal or emotional problems which cannot be discussed adequately in a busy dialysis unit, but on a satisfactory resolution to these problems may depend the effectiveness of long-term treatment. It is here that the domiciliary health team has a part to play.

The provision of home renal dialysis is expensive, but it is effective. Without dialysis patients would die; with it, many are restored to a relatively active life, some returning to employment. It cannot be claimed that chronic intermittent renal dialysis at the present time is the answer to irreversible renal failure, and it is hoped that with the rapid advance in transplant techniques it will be relegated to a useful short-term measure while patients await the availability of suitable donor kidneys.

THE DEVELOPMENT OF SWIMMING POOLS AT TRAINING CENTRES AS PROJECTS FOR VOLUNTARY BODY PARTICIPATION

D. E. Jeremiah, Principal Medical Officer

Swimming as a recreational and useful activity is part of the general curriculum in schools for the normal child. With the severely subnormal child however, great reservations have been held for many years and many excuses have been found for preventing the development of this skill. The first approach to provide swimming facilities for the severely subnormal child at the local swimming baths was made in March, 1963, by Miss M. Reynolds, the Supervisor of the Harrogate Training Centre. Until 1965 children were taken in small parties to the local swimming baths from the Harrogate, West Ardsley and Wombwell Training Centres. In March, 1965, Dr. Appleton, Divisional Medical Officer of the Goole Division, stated it was not convenient to arrange for swimming lessons as the nearest public baths to Rawcliffe Training Centre were situated in Goole at a distance of four miles and that bus transport was infrequent. He also knew that there was a big demand for the use of these baths; some of the local schools could not get as much time allocated to them as they would like and were restricted; he thought in the circumstances it would be very difficult to get time allocated for children from the training centre. At the same time he indicated that the Round Tables at Goole and Selby were interested in aiding the Rawcliffe Training Centre. After discussions on the 13th February, 1967, the Round Tables very generously agreed to purchase all the raw materials for a swimming pool, provide all the labour, and to raise about £1,000 in cash as well. The County Architect estimated the cost of the project to be £1,765 and the value of the direct labour by the Round Tables to be some £400. The County Council therefore had to provide the relatively small sum of about £400, if required. The scheme prepared was for a learner pool 19ft. x 17ft. x 3ft. in the existing patio at the centre. A roof of plastic sheeting was provided and by the erection of a glazed screen the pool was fully enclosed, being protected on the remaining sides by existing walls. Four children are able to receive instruction at the same time and the water is filtered, chlorinated and heated to a maximum temperature of 80°F.

The pool was handed over to the County Council on the 11th October, 1967, by the two Chairmen of the Selby and Goole Round Tables—Drs. J. M. Hulme and D. M. Clark, and officially opened by Alderman W. Hudson, Chairman of the Mental Health Sub-Committee.

On the finalising of accounts it was found that Selby and Goole Round Tablers were able to meet the total cost of the pool.

The success of the Rawcliffe Swimming Pool led to a discussion on the possibility of a swimming pool for the Horsforth Training Centre. On the 1st November, 1967 the Divisional Medical Officer, Dr. Burn, indicated to the Visiting Sub-Committee that financial help would be forthcoming from the

local Round Tables. On the 23rd October, 1968, the Secretary of the Wharfedale Group of Round Tables wrote indicating that the fund stood at about £4,000 and that they were anxious to start work as soon as possible as building costs were continually rising. An architect member of the Round Table had designed a pool to meet the requirements of the training centre. The suggested scheme was for a pool 15ft. x 18ft. x 3ft. with male and female changing rooms, with a third room to house the plant and equipment. The pool was sited within a quadrangle and enclosed on all four sides with access from the existing corridors. The whole area was to be roofed in and the pool and air space would be heated. A rough estimate placed the cost at £6,500. The final figures in this respect were £6,150 for the project to which the magnificent sum of £4,750 was donated by the Wharfedale Group of Round Tablers, the balance being met by the County Council.

Various voluntary organisations are raising funds for the provision of swimming pools at the following three centres:

Kirkburton Training Centre

The fund stands at approximately £3,000

Rothwell Training Centre

The fund stands at approximately £2,500

West Ardsley Training Centre

The fund stands at approximately £2,700

The Department of Health and Social Security does not include swimming pools in the *Building Notes for Training Centres*. With the increased interest in the provision of swimming pools at centres, the Departments of Central Government may well think it appropriate to consider the need for such standards. Swimming pools are not only useful and pleasant but are a valuable aid in the training and education of the severely subnormal child. The policy of the West Riding County Council is to encourage and give financial support to voluntary organisations willing to participate in the provision and development of this particular activity.

SPINA BIFIDA CYSTICA

C. Simpson Smith, Principal Medical Officer

As a result of immunisation against poliomyelitis the incidence of physical handicaps following this condition has fallen dramatically over the last decade. Orthopædic tuberculosis in childhood is also a rarity, unlike the days when schools for the physically handicapped had a large number of children with deformed spines and joints. Other diseases such as cerebral palsy, congenital scoliosis, and Perthes' disease appear to be fairly static in incidence.

The major problem of the physically handicapped child is now spina bifida cystica. This abnormality has been recognized for many years but the majority of sufferers died in early infancy from added infection such as meningitis. The condition is frequently associated with congenital hydrocephalus and, in the past, this frequently resulted in death from pressure on the brain tissue.

Spina Bifida is a congenital deformity of the spine due to a failure in the course of development in the fusion of certain parts of one or more vertebræ. Through the opening caused by this failure a swelling may protrude which contains fluid and often some nerve tissue. This swelling, which is called a meningocele, may be situated anywhere along the spine but is most common in the lower part of the back or lumbo-sacral region. While it may consist mainly of the membranes covering the spinal cord (meninges) and cerebro-spinal fluid with no nerve tissue involved, in the more serious variety (myelomeningocele) the spinal cord and nerve roots also pass out into the swelling and the stretching of the nerve tissue is likely to give rise to paralysis of the legs, bladder and rectum. The swelling may be covered by skin or more often by a thin almost transparent membrane which readily ulcerates and results in infection and meningitis. In its simplest form, *spina bifida occulta*, there is no swelling and no disability although the defect in the spinal column is shown on X-ray examination and the site may be indicated by a dimpling of the skin or by an overlying hairy mole. *Spina bifida occulta* is a common condition affecting about 4·5 per cent. of the population. It has no adverse effects. Meningocele and myelomeningocele are referred to as *spina bifida cystica* and are the ones which cause a significant handicap. The condition is partly familial, and a higher proportion of parents of affected children have *spina bifida occulta* than in the normal population. While a genetic factor is probably involved, the mode of inheritance has not yet been elucidated.¹

Although the kinds of cases selected for operation vary at different hospitals it is generally accepted that an operation on a myelomeningocele within the first 24 hours of life is most important, preventing deterioration in the child's condition due to damage to the exposed nerves and by infection. This early closure of the defect in the spine is followed by further surgery to correct other handicaps; but many children are left with paralysis of the lower limbs and incontinence, the latter often associated with urinary infections. The incontinence can be mitigated by operative treatment and the wearing of a belt with a suitable container.

In hydrocephalus there is an excessive accumulation of cerebro-spinal fluid inside the skull. It is frequently congenital, may arise from a brain hæmorrhage during birth, or from meningitis after birth. In about half the congenital cases the condition does not progress beyond a certain point. The effect on the child's mental development depends on the degree of brain damage from the pressure of the excess fluid. Contrary to earlier views it is possible for a child with a very large head to have little impairment of intelligence. Before present methods of treatment became available, in many cases the condition progressed and was fatal. Nowadays the infant is kept under regular observation, with periodic measurements of the circumference of the skull, and active treatment is undertaken if the condition is shown to be progressive. The use of the Holter valve allowing the drainage of the fluid from the brain into the blood-stream, started in Great Britain in 1958, caused dramatic changes in the outlook for the child with hydrocephalus. Previous surgical procedures had been complicated and unsatisfactory.

Incidence:

Dr. John Lorber, of Sheffield, reports² that 85 per cent. of children with myelomeningocele also have hydrocephalus.

The incidence of spina bifida cystica varies in different parts of the world and according to the origin and race of the inhabitants. In Boston, Massachusetts, Irish infants had a much higher incidence than those of Jewish origin. In England and Wales in 1966 there was a rate of 1·4 per 1,000 live births varying from 0·98 in East Anglia to 1·75 in the East Midlands and 1·87 in South Wales. In Northern Ireland the figure was 3·1 per 1,000 births. An earlier study in Birmingham from 1960 to 1962 showed an incidence of 2·0 per 1,000 births but 22 per cent. of these were stillbirths—1·56 per 1,000 being live births.³ The regional variations are the subject of continuing research.

In the West Riding figures are now being compiled from the records of congenital abnormalities and from other sources. Although they are not complete so far they give an indication of the general pattern.

<i>Year</i>	<i>Stillbirths</i>	<i>Live Births</i>	<i>Total</i>
1965	Figures not available	26	26
1966	Figures not available	36	36
1967	2	37	39
1968	6	50	56
1969	7	43	50

It would appear that the incidence in this area is around the national figure of 1·4 per 1,000 live births although there are variations from year to year as has been mentioned in other surveys.

Survival Rate:

This figure is changing as a result of improved surgical techniques. The majority of deaths occur during the first year of life. Lorber considers that at least 40 per cent. of children born alive with spina bifida will now survive until school age. A follow-up of children born between 1956 and 1962 in South Wales showed that 16 per cent. were alive aged $2\frac{1}{2}$ - $9\frac{1}{2}$ years,⁴ this was without surgical treatment. A study in Liverpool⁵ from 1960 to 1962 suggested that, with early operation, at least 56 per cent. of all children who survive the first few hours of life will continue to live and that improvement in operative techniques may result in a figure approaching 70 per cent.

Lorber's² follow-up of children treated in the unit at Sheffield showed that 56 per cent. of infants admitted in 1959 and 1960 were alive in 1965. Of these, 10 per cent. were severely subnormal, 19 per cent. were educationally subnormal with or without associated severe physical handicap, 27 per cent. of the survivors had no physical handicap and were mentally normal, and the remaining 44 per cent. had physical handicaps requiring special education though not necessarily in a special school. Thus over 60 per cent. of surviving children are likely to require some form of special education either because of physical handicap, educational subnormality, or a combination of both.

From the records now being kept for the West Riding five of the children born alive in 1969 died during the early weeks of life and 14 of the children born in 1968 also died. On present evidence it would appear that between 35-40 children per year are likely to survive until school age and the number is likely to increase. This is twice the number of children surviving until recently.

Educational Problems:

Dr. A. L. Smallwood of Bristol,⁶ lists the following difficulties in day-to-day management.

1. The leg paralysis and lack of locomotion often lead to undue weight gain in older children who are difficult to lift.
2. The defective urinary and bladder control cause particular difficulty.
3. Skin infections and ulcers are common at points which take pressure in those parts of the body which have been damaged or are absent.
4. Learning difficulties, similar to those in spastic children, may occur when the child also has a hydrocephalus.
5. Emotional problems, commonly associated with children who have physical handicaps, are also seen.

Dr. Smallwood remarks "It does little service for doctors and others to allow parents to think that their afflicted child must go to an ordinary school as opposed to a special school or class."

Professor Jack Tizard⁷ has surveyed the literature and outlined the social and educational problems involved. The strains on the parents of children with spina bifida are likely to be more severe than with cerebral palsy. For the child the likelihood of frequent periods in hospital during the early years with temporary separations from his parents presents particular problems for his psychological well-being.

Opinions regarding the educational provision for these children vary considerably. Some consultants feel that all children should be educated within the ordinary school system, however severe the degree of physical handicap, if mentally normal. This is often unrealistic as Dr. Smallwood implies. Others take the view that the children should be admitted to specialized boarding schools. Many children with severe physical problems do cope with the ordinary school curriculum, when in a sympathetic environment. More could be accommodated in the ordinary schools, if money could be spent on ramps, special toilet facilities, and ancillary help to assist in toilet arrangements for the incontinent; but too high a proportion of handicapped children in any one school could have an adverse effect on the general progress of the other children.

Although special schools catering solely for spina bifida children are in being, and others are planned, the general trend in thinking is away from the provision of highly specialized schools and many spina bifida children attend school taking in various physical handicaps. It has been found that the numbers have to be somewhat restricted in any one school in the absence of special nursing help.

The increasing number of survivors is now presenting education authorities with the problem of placement. New day schools for the physically handicapped are planned for the Yorkshire area. These will need special provision for wheel chairs, toileting arrangements and ancillary staff to cope with nursing needs.

The following table shows the present educational placement for children of school age in the West Riding:

	Year of Birth										
	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954
<i>Placement:</i>											
No Education (Grossly handicapped mentally and physically)	—	1	—	—	—	—	—	—	—	—	—
On Home Tuition	1	—	1	1	—	—	—	—	1	1	—
<i>At Schools for the Physically Handicapped</i>											
Day	5	7	4	2	1	1	2	1	4	—	2
Residential	3	10	3	4	10	6	5	2	7	4	1

At Ordinary Schools

Coping adequately
(Mainly meningoceles with
little residual defect)

5 6 1 2 1 - 1 - 2 1 -

Awaiting Special Schools

- 3 - - 1 1 - - - - -

Trial at Ordinary Schools—
will probably need Special
School later

7 2 4 3 - 3 - 1 - - -

At Training Centres for
Subnormal Children

- - 2 1 1 - - 1 - - -

TOTALS

21 29 15 13 14 11 8 5 14 6 3

Recent deaths during
school age

- - 2 - 1 - 2 1 - - -

Thus only 19 of the 139 surviving children of school age are really coping reasonably in the ordinary schools (14.4 per cent.). A further 20 are attending ordinary schools but have severe handicaps and may need to be admitted to special schools for their secondary period as they would be unable to cope with large buildings and constant movements of classes.

Other Problems:

One of the medical aspects which has not yet been overcome is that of recurrent *urinary infections* leading to kidney conditions. This may lead to death as in the cases noted in the table and will have an effect on the expectation of life.

A further problem to be faced is the *emotional* one. Apart from the usual frustrations of the physically handicapped child, these children in the main suffer from general paresis from the waist downwards and with the onset of adolescence they will realise that they can never, especially in the male, achieve parenthood. The distribution of intelligence where the hydrocephalus has been treated successfully is that of the normal population.

Conclusion:

With the increasing number of children surviving, the problem of the educational placement of handicapped spina bifida pupils is becoming acute. Many surveys are being carried out to assess the size of the problem. No simple answer is possible and many aspects will have to be considered in placing the individual child: familial, emotional, and local school facilities as well as the particular physical aspects in each case. The school physician, with local knowledge of the families and schools, will have an important part to play in equating the physical needs of the child, as seen by the consultants, with local facilities available.

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Acknowledgment

A shorter version of this essay, entitled 'Spina Bifida and Hydrocephalus' appeared amongst a group of short essays under the generic title of the 'Handicapped Child in the Ordinary School' in *Well-being* (Vol. 1, No. 4.) which is published each term by the West Riding Education and Health Departments.

PART I

VITAL STATISTICS

EPIDEMIOLOGY

VENEREAL DISEASE

RESEARCH

See also Tables 1 to 36 of Appendix A

VITAL STATISTICS

Area and Population:

		Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	... ..	380,333	1,226,166	1,606,499
Population:				
Census, 1961	...	1,187,034	450,884	1,637,918
Estimated (mid-1969)		1,265,770	520,510	1,786,280

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Summary for 1969:

		Adminis- trative County	England and Wales
Live Births			
Number	... ..	30,274	
Rate per 1,000 population	... ..	16.9	16.3
Illegitimate Live Births			
Number	... ..	2,002	
Per cent. of total live births	... ..	6.6	8.4
Stillbirths			
Number	... ..	415	
Rate per 1,000 total live and still births	... ..	13.5	13.2
Total Live and Still Births...	... ..	30,698	
Deaths: All causes	... ..	20,798	
Rate per 1,000 population	... ..	11.6	11.9
Infant Deaths (deaths under 1 year)	... ..	573	
Infant Mortality Rates			
Total infant deaths per 1,000 total live births	... ..	18.9	18.1
Legitimate infant deaths per 1,000 legitimate live births	... ..	18.6	17.4
Illegitimate infant deaths per 1,000 illegitimate live births	... ..	23.5	25.4
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	... ..	12.3	12.0
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	... ..	10.3	10.3
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births)	... ..	23.7	23.4
Maternal Mortality (including abortion)			
Number of deaths	... ..	6	
Rate per 1,000 total live and still births	... ..	0.20	0.19

Live Births:

The decline in the birth rate continued: there were 952 fewer births than in the previous year and the resultant crude rate of 16·9 per 1,000 population, although maintaining a higher level than national, is the lowest recorded since 1960.

It is significant that the reduction in the rate of 0·7 per 1,000 population is the largest annual decrease since 1950 and there are indications that there will be slightly fewer births in 1970. The pattern is similar to that evident subsequent to the post-war bulge in births and it seems likely that the rate will pursue a downward trend for the next decade. The birth rate adjusted for variations in the age-sex structure of the population for the aggregates of Boroughs and Urban Districts was 17·2, for Rural Districts 16·7, and the Administrative County 17·1, which compare very favourably with the rate of 16·3 for England and Wales.

The reduction in total live births was accompanied by a proportionate decrease in the number of illegitimate live births: there were 2,002 registered as illegitimate representing 6·6 per cent. of live births, the same proportion as in 1968. Although this rate continues to be lower than national (8·4 per cent.) it is the highest level recorded since 1945. Details of the cases dealt with under the Authority's scheme for the care of the unmarried mother and her child are given in Appendix A.

Stillbirths and Infant Mortality:

STILLBIRTHS:

There was a decrease of 39 stillbirths and a rate of 0·8 per 1,000 total births compared with the previous year; the number of births and the rate are the lowest recorded. That the County rate continues to be slightly higher than national suggests that further improvement is possible. Only 19 stillbirths (4·6 per cent. of total stillbirths) were born out of wedlock.

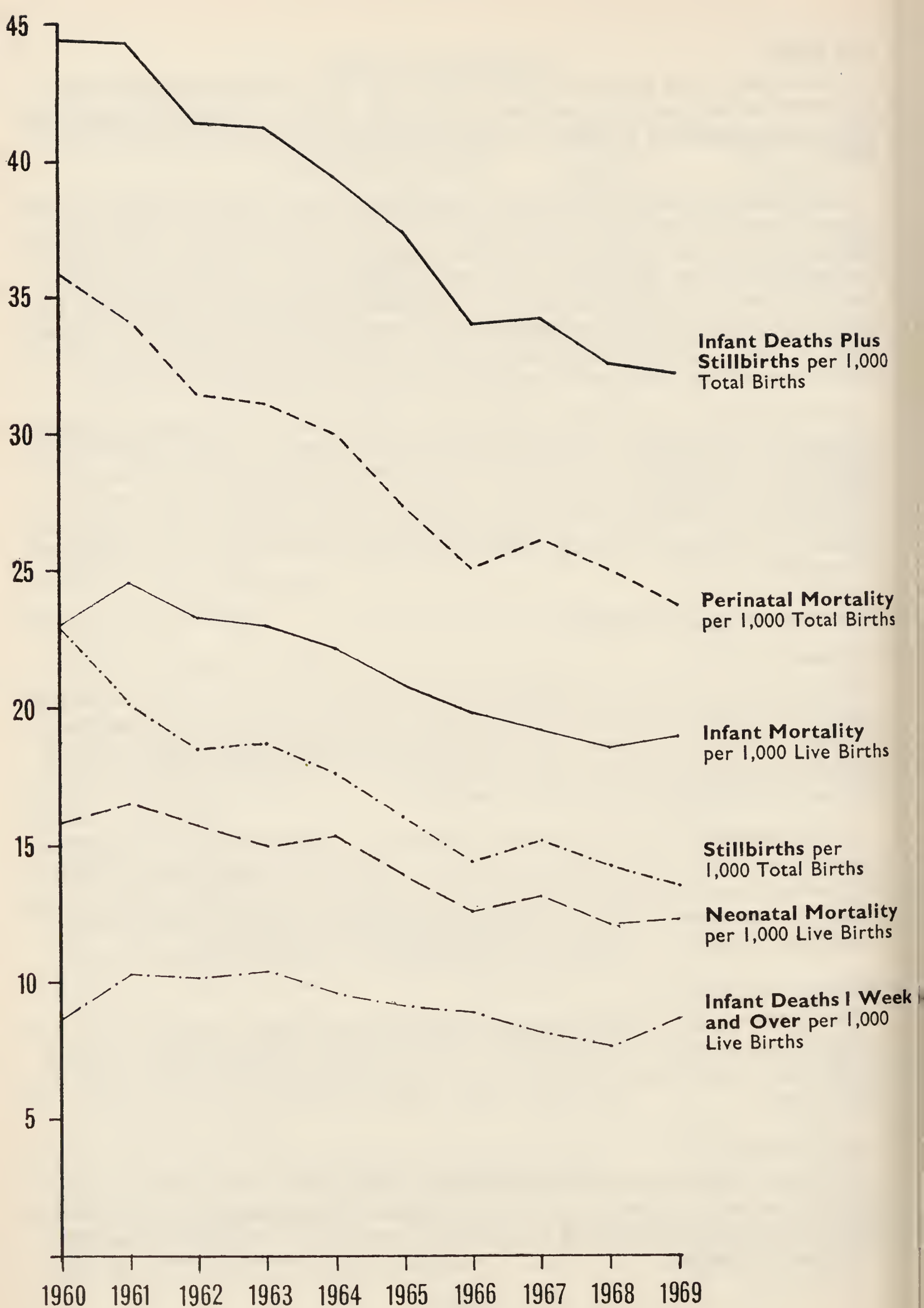
A requirement of the Population (Statistics) Act, 1960, is that medical practitioners, or in their absence, midwives, record the cause of each stillbirth they deliver, the estimated duration of the pregnancy, and the weight of the foetus, if determined. The number of stillbirths allocated to cause and the corresponding rates per 1,000 total births are given in Appendix A.

PERINATAL MORTALITY:

The improvement in the rate was maintained to reach a new low level. As usual, the involvement of prematurity was apparent and 68 per cent. of infant deaths under one week and 59 per cent. of the stillbirths, had a birth weight of 5½lb. or less.

INFANT MORTALITY:

In the past twenty years the rate has halved; the greatest reduction occurred at ages three months to one year. First day deaths after a prolonged period of little change were considerably fewer in the last six years but still constitute 30 per cent. of total infant deaths.



It is disappointing to record that a slight setback occurred with the rate increasing by 0·4 per 1,000 live births compared with 1968: all age groups from the second day of life up to six months effected an increase with females aged 1-4 weeks making the major contribution. The rate, however, was the second lowest on record.

The County rate continues to be higher than that of England and Wales and certain other countries, which indicates that the irreducible minimum has not yet been reached.

Illustrated graphically are the trends of the rates associated with loss of foetal and infant life during the past ten years.

Deaths:

The crude death rate of 11·6 per 1,000 population was the same as in 1968 and continued to be slightly lower than national. The death rates from all causes, adjusted by the comparability factors were, for the aggregates of Municipal Boroughs and Urban Districts 12·9, Rural Districts 12·0, and the Administrative County 12·6, which compare with a rate of 11·9 for England and Wales.

Major causes of death were heart and circulatory disease (excluding cerebrovascular disease) which represented 37·7 per cent. of total deaths (37·3 per cent. in 1968), malignant neoplasms 18·0 per cent. (18·4), cerebrovascular disease 14·6 per cent. (15·2), respiratory diseases 14·6 per cent. (14·3), violent causes 4·6 per cent. (4·5).

Although total mortality from cancers fell slightly, concern must be expressed at the rise in male deaths from lung cancer. Approximately one in every thousand men is now dying from this disease each year. Female death rates from this cause now average 0·2 per 1,000 women per annum with a slight upward trend in evidence.

PRE-SCHOOL AGE (1-4 years):

In the period 1911-15 the annual average death rate per 1,000 living in the age group was 17·13; by 1935-39 the rate had reduced to 5·09 and in 1960-64 to 0·97. Since then further slight gains have been made and mortality has fluctuated around the level of 100 per annum and a death rate of 0·80. In 1969 there were 102 deaths representing a rate of 0·83 per 1,000 living in the age group. The virtual control of infectious diseases and those diseases mainly infective in origin has resulted in accidents and congenital malformations now being the most frequent causes of death. In 1969 these latter causes accounted for 38·2 per cent. and 12·7 per cent. respectively of deaths in the age group.

SCHOOL AGE (5-14 years):

Although the lowest death rates at any age are recorded for this group, further diminution could be achieved if the deaths from violent causes, which are largely preventable, were eliminated. In recent years almost half the mortality in the age group has been due to violent causes, notably motor vehicle accidents, with boys most frequently the victims in the ratio of 3:1.

Mortality from congenital malformations and cancer remain around the same level as previously but deaths from infectious disease, and rheumatic fever and its sequelæ, are now of negligible proportions. It is significant however, that while leukæmia is a minor contributor to total mortality, 9·4 per cent. of deaths in this age group were classified to this cause.

ADOLESCENCE AND AFTER (15-24 years):

There have been only slight variations in the causes of mortality during the past decade. Cancers and diseases of the respiratory system continued to take their toll but deaths from violent causes predominated and accounted for 59 per cent. of mortality in the age group. Motor vehicle accidents made the major contribution with male deaths significantly more numerous; of the total male deaths in the age group, 46·7 per cent. were attributable to this cause.

YOUNG ADULT (25-34 years):

During the past 20 years mortality in this age group has pursued a gradual downward trend. The age/cause of death distribution conformed to the usual pattern with male deaths in excess in the ratio of 2:1. Deaths from violence were most frequent, followed by cancer and diseases of the circulatory system.

ADULT (35-44 years):

At these ages, while the general death rate remains low, some of the most frequent causes of total mortality, notably cancer and diseases of the circulatory system, start to become manifest. For males, deaths from ischæmic heart disease, violent causes, and lung cancer were prominent and in females cancer of the breast and uterus, and cerebrovascular disease. There was a slight excess of male mortality.

MIDDLE LIFE (45-64 years):

The commonest causes of death, in descending frequency, were ischæmic heart disease, cancer, cerebrovascular disease, bronchitis and violence.

Ischæmic heart disease has been increasing in recent years, especially in males, and in 1969 more than a third of the male deaths at these ages were from this cause. Of the cancer deaths, the predominant sites were lung and bronchus in males and the breast in females.

OLDER AGES (65 years and over):

The effective control of, or reduced mortality from, most infectious diseases has been the major factor in enabling increased numbers of the population to survive well into their second half century, so bringing the degenerative diseases into greater prominence.

Two thirds of the total deaths were at these ages with the mortality pattern evident in middle life being broadly continued at older ages. Up to 75 years of age there was an excess of male mortality but thereafter female deaths predominated.

The level of mortality appears to be now stable for both sexes.

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

Following the introduction of The Public Health (Infectious Diseases) Regulations, 1968, on the 1st October, 1968, no fewer than 22 separate Regulations relating to infectious diseases were revoked, and listed below are the diseases which are now statutorily notifiable.

Acute encephalitis	Ophthalmia neonatorum
Acute meningitis	Paratyphoid fever
Acute poliomyelitis	Plague
Anthrax	Relapsing fever
Cholera	Scarlet fever
Diphtheria	Smallpox
Dysentery (amœbic or bacillary)	Tetanus
Food poisoning	Tuberculosis
Infective jaundice	Typhoid fever
Leprosy	Typhus
Leptospirosis	Whooping cough
Malaria	Yellow fever
Measles	

The tables in Appendix A summarise the age and sex distribution of cases notified during 1969 and where applicable, a comparison is given of the notifications during the past six years.

ACUTE ENCEPHALITIS:

Only one case of the infective form was confirmed: this was a boy of three years who made a complete recovery.

ACUTE MENINGITIS:

Forty-eight cases were notified of which 12 were at ages under 5 years, 10 in the age group 5-9 years and six aged 10-14 years. There was a preponderance of males in the ratio of 1·7:1.

Overall there was increased prevalence in the south of the Riding in the second half of the year which continued through to January, 1970. No apparent connection could be discovered.

ACUTE POLIOMYELITIS:

In the past four years there has been only one case confirmed, a boy who suffered from the paralytic form in 1968. The success of the scheme of vaccination against the disease is clearly underlined but cases continue to occur infrequently in the country which emphasises that if the disease is to be eradicated, vaccination rates must be kept at the highest possible level.

Vaccination against Poliomyelitis:

At the year end, the total number of persons protected against poliomyelitis in the county, taking into account both Salk and Oral vaccine, was 848,509.

ANTHRAX:

From 1960, when the disease in humans became notifiable, to 1966, a total of eight cases has been notified in the administrative county, since when no case has been reported. The Authority's scheme of vaccination of workers particularly exposed to the risk of contracting the disease continues.

DIPHTHERIA:

No case has been reported since 1964. This satisfactory situation must not however encourage complacency for there is still the need to maintain effective immunisation protection of our child population.

DYSENTERY:

The number of corrected notifications fell from 691 in 1968 to 476. The disease appears to be endemic in certain areas with occasional flare-ups, but generally it does not reach epidemic proportions. There was no outbreak of any significance, the cases occurring sporadically with no traceable connection.

Of the cases confirmed bacteriologically, by far the majority were due to *Sh. sonnei*. The infections were generally mild but there was one death, a three month old girl who died from toxæmia and on autopsy *Sh. sonnei* was discovered in her stools.

Direct or indirect personal contact are the principal modes of spread of the disease. The usual concept is of faecal infection being transmitted by the hands of infected persons and, while other measures may contribute in curtailing or combating the infection, the easiest and most successful method of prevention is the thorough washing of the hands after every visit to the toilet.

ENTERIC FEVERS:

Typhoid Fever:

In 1941, typhoid and paratyphoid fevers became separate entities for notification purposes. Since that time the annual number of notifications of cases of typhoid have fluctuated within the range of nil to 27; in 1969 no case was confirmed.

Indigenous cases usually contribute about half the notifications and medical officers of health and their staff are alert to eliminate all possible sources of infection. A number of the imported cases arise from time to time in persons returning from visits abroad; the majority of these cases are preventable by effective vaccination. West Riding school parties proceeding on holiday to

countries bordering on the Mediterranean Sea and certain parts of Europe continue to be advised to be adequately vaccinated against typhoid and paratyphoid fevers. It is also impressed on the parties that vaccination does not replace the need for high standards of hygiene. These instructions were issued some years ago and that no incidents have been reported underlines the effectiveness of these precautionary measures.

Paratyphoid Fever:

Two cases were confirmed, a 46 year old man who had holidayed in Morocco and a boy of eight years who had been on a family holiday to Tunisia. There was no connection between the cases and no other members of the respective families were ill.

FOOD POISONING:

The number of incidents were fewer than in the previous year; there were 109 notified cases and two further cases ascertained during the course of investigations. Summarised below are the types of incident and the major microbial causes.

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella typhimurium	1	2	—	—	19	21
Other Salmonellæ	4	11	—	—	17	28
Cl. welchii	—	—	1	30	1	31
Staph. aureus	—	—	2	12	3	15
Not discovered	1	3	—	—	13	16
All agents	6	16	3	42	53	111

In addition there were 12 cases of salmonella infection not food-borne

The outbreak of Cl. welchii occurred in a party of old people who went to Morecambe for a day's outing. Of the 96 people concerned, 30 were infected. The food incriminated was oven-roasted frozen chicken which formed part of a cooked lunch taken at a restaurant. Intensive investigations were undertaken by the medical officer of health for Morecambe and his staff, from which it appeared that contamination probably occurred at the time of slaughter of the chickens with a subsequent breakdown in kitchen hygiene. Recommendations and requirements of the medical officer of health were effected at the restaurant and further food samples taken there proved negative.

The above demonstrates that food poisoning continues to be a problem and a challenge. Imperfect kitchen techniques of cooking, cooling and storage carry unnecessary risks as does carelessness. The infection could be virtually eliminated if all concerned in the preparation, cooking and handling of food adhered to a rigid code of kitchen hygiene and practice supported by clean food handling.

INFECTIVE JAUNDICE:

Of the total of 756 notifications, 400 (52.9 per cent.) related to children aged 5-14 years. Seasonal incidence was higher in the first and last quarters and appreciably lower in the third.

There were a number of sporadic cases but the majority of notifications arose from minor outbreaks. In the Skipton Division over half the cases notified came from an outbreak which originated in a primary school and spread to the neighbouring parish. A total of 58 cases occurred, 38 children and 20 adults, all near-relatives of the infected children. Whereas the illness was mild in children many of the adults were seriously ill, two being admitted to hospital. Fortunately none of these cases died.

No fewer than 19 of 26 notifications received in a County District in the Rothwell/Wetherby Division were from an outbreak in a closed community of subnormal patients. There was an explosive onset, half the cases occurring within the first three days with a second wave 20 days later. Again there was no death.

In addition to providing more precise information of incidence, the introduction of general notification has enabled medical officers of health to inquire into the epidemiological background and modes of spread of the disease. Information on cases and household contacts among blood donors is passed by the medical officers of health to the Directors of the Regional Blood Transfusion Units; this should obviate the risk of hepatitis following transfusion with blood donated by an infected person.

MALARIA:

There was no case of therapeutically induced malaria reported, the two cases notified contracted the disease abroad. There was one death, a 27 year old woman who had recently returned to this country after being abroad for 2 years. She died suddenly and the subsequent Coroner's post-mortem gave the cause as cerebral malaria.

MEASLES:

In the past it has been usual for the disease to assume epidemic proportions during autumn through to spring biennially; since 1962 however, this cycle has not been in evidence and notifications have ranged between 13,000 and 20,000 per annum. The number of notifications in 1969 declined to 3,392, the lowest recorded total since 1956 with incidents more frequent in the first and second quarters of the year.

As in previous years, children under 5 years of age were most heavily involved (60 per cent. of notifications), followed by children in the 5-9 years age group (35 per cent.).

The disease continued to be mild and no death was reported. This marked reduction in incidence can reasonably be ascribed to the effects of vaccination and on page 74 a review is given of the Authority's participation in the Medical Research Council's trials of measles vaccines which preceded the introduction of the general scheme which made vaccination available to all susceptible children under the age of 16 years.

Measles Vaccination:

The number of persons who received vaccination against measles during the year was as follows:

Born in Year							
1969	...	...	...	...	...	...	2
1968	...	...	...	...	...	...	1,861
1967	...	...	...	...	...	...	5,170
1966	...	...	...	...	...	...	2,721
1962-65	...	...	...	...	...	...	3,884
1953-61	...	...	...	...	...	...	894
							<hr/>
Total							14,532
							<hr/>

This is a very appreciable drop in total vaccinations when compared with the figure of 25,498 for 1968 which is accounted for very largely by the long period during 1969 when vaccine was in extremely short supply.

OPHTHALMIA NEONATORUM:

Only two cases were reported, both responded to treatment with no loss of vision.

SCARLET FEVER:

Notifications numbered 1,053 representing an attack rate of 0.59 per thousand population, compared with 794 notifications (attack rate 0.45) in 1968 and an average of 1,212 (0.70) in the years 1964-68. The majority of cases were mild and were nursed at home: no death was recorded.

SMALLPOX:

The County has been free from the disease since 1962. The risk of importation from endemic areas however remains, and parents must be continually reminded that in these days of air travel the disease could be introduced at any time. Every effort is made towards protecting the young child by vaccination in the second year of life and re-vaccination at 5 and 15 years.

TETANUS:

Notification of the disease was introduced on 1st October, 1968, since when no case has been reported.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1969 was 19,796. A secondary or reinforcing injection was given to 30,869 children.

Dr. T. D. Spencer, Assistant Chief Medical Officer of the National Coal Board Headquarters Medical Service at Doncaster, writes as follows on the immunisation of coal miners against tetanus:

“There was a total of 2,294 completed immunisations during the year. Nearly all of these were on new entrants, a comparatively small number were on men who had their immunisation commenced at hospital and were completed at the collieries. Very few were volunteers amongst miners already in the industry. It appears likely that figures for immunisation will settle down at something like this level from now on, but the total percentage of miners immunised is, of course, rising each year.”

WHOOPING COUGH:

There was a further substantial decrease to 181 notifications, the lowest number ever recorded; there was no death. The age-sex distribution conformed to the usual pattern; 15.5 per cent. of the notifications were of children under one year, 54.1 per cent. aged 1-4 years and 21.5 per cent. aged 5-9 years. Although a high risk to infants under one year persists, the disease appears to be under control.

Immunisation against Whooping Cough:

During the year 16,319 children completed a full course of immunisation against whooping cough and since facilities were introduced in 1952 a total of 310,661 have been immunised under the County scheme. The number of children in the 0-4 years age group was 70,648 representing 64.2 per cent. of the total population in this age group. Of the 175 notifications of whooping cough in the 0-14 years age group 74 concerned children who had been immunised.

INFLUENZA:

As the disease is not statutorily notifiable, the most reliable index of morbidity is the weekly notifications of new claims to sickness benefit issued by local offices of the Department of Health and Social Security, supplemented by information of school and industrial absentees.

During February/March increased prevalence with sporadic outbreaks was reported in various parts of the county, particularly in northern areas. Although the illnesses were generally mild there was increased seasonal mortality among elderly people with influenza a contributory cause.

In mid-December a sharp rise in the incidence of influenza cases was reported in most European countries. The infection quickly spread to London and the south-east of England and subsequently to the Midlands and the West Riding where, initially, the Goole, Wharfedale, Harrogate and Doncaster areas were affected. Although cases of the disease were reported in children, by far the majority of incidents were of adults. General practitioners were under considerable pressure and medical wards of the local hospitals were fully occupied with influenza, bronchitis and pneumonia cases which necessitated the suspension of non-urgent admissions.

At that time the epidemiological picture was confused as two clinical entities appeared to be involved: one of running nose and eyes, with a persistent dry cough and typical of laryngeal infection, and the other of vomiting, raised temperature, aching limbs and in some cases complete prostration followed by periods of deep depression. Subsequent laboratory isolations confirmed that two viruses were implicated—Echo 9 and influenza A2/Hong Kong/68. The outbreak due to Echo 9 virus subsided and influenza infections predominated.

In regard to influenza cases, the length of illness appeared to be sharply defined: children and teenagers were ill for less than a week but adults not less than two weeks. In certain areas severe complications were reported which were reflected in the death rates not only in the elderly but also in comparatively young people.

At the year end it became apparent that the influenza epidemic was to become widespread throughout the county and indeed increased prevalence continued in most areas through to the end of January, 1970.

VENEREAL AND SEXUALLY TRANSMISSIBLE DISEASES

In recent years attention has been drawn in this report to the apparent increase in gonorrhœa and sexually transmissible diseases and the decrease in syphilis. This trend continued in 1969. New cases attending special clinics can be allocated after diagnosis into four groups. In 1969 the approximate percentage of cases in each group was as follows:

A. Sexually transmissible and other genito-urinary diseases	50 per cent.
B. Cases not requiring treatment	33 per cent.
C. Gonorrhœa	16 per cent.
D. Syphilis	1 per cent.

The venereal diseases are defined by statute as syphilis, gonorrhœa and chancroid. There were no cases of the latter disease during the year hence the percentage of cases of venereal disease was 17 per cent.

A. Sexually transmissible and other genito-urinary diseases. This group comprised 1,695 new cases (1,129 males and 566 females)—an increase of 11 per cent. compared with the previous year. Of the cases in males 55 per cent. were suffering from non-gonococcal urethritis and of those in females 33 per cent. had trichomoniasis. The remaining cases included condylomatosis (genital warts) and candidosis, both of which have become increasingly prevalent in recent years. Candidosis (genital thrush) was found frequently in females, especially in pregnant women and in those taking contraceptive pills.

B. Cases not requiring treatment numbered 1,136—a 15 per cent. increase. Patients in this group included babies for pre-adoption examination and blood tests, unmarried expectant mothers, uninfected individuals who had exposed themselves to possible infection and patients with symptoms or signs suggesting a venereal or sexually transmissible disease but who after examination and tests, were found to be free from any of these diseases.

C. Gonorrhœa cases numbered 537, an increase of 6 per cent. Of 347 cases in males, 16 per cent. (12 per cent.) were under 20 years of age. Of 190 cases in females, 38 per cent. (22 per cent.) were under 20 years of age. The bracketed percentages are those of the previous year. The trend in the last decade has been for an increasing number of cases of gonorrhœa to be found in adolescents. This increase may be only partly a true increase because the present generation of teenagers are less reluctant to attend special clinics for examination than their predecessors. Also doctors in general practice and in hospital clinics refer some cases for examination which formerly they would have treated themselves.

D. Syphilis. The number of new cases of all types of syphilis decreased by 17 from 47 to 30. There were no cases of congenital syphilis in infants under one year of age and only nine cases of early infectious acquired syphilis.

More than a year has elapsed since the publication of the Department of Health and Social Security memorandum on contact tracing. It was hoped that this circular would result in a considerable increase in case-finding. It is disappointing to note, therefore, that although there were 2,262 (2,083) cases of venereal and genito-urinary diseases only 68 (60) contacts were reported to the County Medical Officer in 1969. The bracketed figures are those for 1968. Eighty-five per cent. of the contacts reported were located by the social workers and 70 per cent. were persuaded to attend a clinic for examination. The solution to this problem may lie in a better liaison between hospital and public health workers. This may be achieved as a result of the proposed unification of the various branches of the National Health Service.

It is only fair to add that some V.D. statisticians believe that the nearer the ratio of male/female cases of gonorrhœa approaches 1:1 the better the contact tracing. As a matter of interest therefore the administrative county ratios for the last nine years are included in the statistical section. The 1969 ratio was 1·8:1. The corresponding ratio for the whole of England and Wales 2·4:1.

RESEARCH PROJECTS

Survey of Childhood Cancers:

The department's participation in the national survey of childhood cancers conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University has continued. This survey includes the investigation of childhood deaths from cancer in the period 1961-67 and at the year end, of the 246 cases relating to the Administrative County, enquiries into 205 cases and their age/sex paired controls had been completed.

Although the work undertaken by the medical staff is very time consuming, on average at least one day being necessary to successfully investigate each case and its control, the interim findings indicate that the effort involved is amply justified and various leads have suggested fields for further research.

Measles Vaccines Trial:

In the autumn of 1964 the Authority agreed to take part in a large-scale trial of measles vaccines under the auspices of the Medical Research Council's Measles Vaccines Committee. The trial was planned to assess the value of the vaccines for general use and this required special attention being given to the degree and frequency of reactions following vaccination, also the extent and duration of protection.

During October/November, 1964 and September/October, 1965 some 3,510 children, in the susceptible age group of 10 months to 2 years, resident in certain parts of the Administrative County whose parents had voluntarily agreed to them taking part in the trial were vaccinated with killed vaccine, followed four weeks later with a dose of live vaccine: the vaccinations were undertaken by the Authority's medical officers. These children were followed up by health visitors at three weeks to assess the reactions to vaccination and at three, six and nine months to record the incidence of measles. Subsequently annual postal follow-ups have been undertaken and visits by health visitors in cases of default.

The Committee's second report, published in 1968, confirmed its previous conclusions that the vaccines gave a high degree of protection and when measles occurred in vaccinated children on average it was milder than the disease in those unvaccinated. These findings enabled the then Ministry of Health to introduce vaccination nationally for all susceptible children up to and including the age of 15 years. Before large-scale programmes of vaccination could be effected the supplies of vaccine from one manufacturer were suspended and there was the inevitable shortage which is reflected in the number of children vaccinated in the general scheme.

The results of the trial obtained so far show that substantial protection was maintained over a period of five years since vaccination; the follow-up of the children involved however, will be continued to obtain the essential information on the duration of protection over longer periods and whether reinforcing vaccinations should be given and, if so, the optimum age for their administration.

PART II

CO-OPERATION IN THE HEALTH SERVICE

DIVISIONAL ADMINISTRATION

See also Table 37 of Appendix A

CO-OPERATION IN THE HEALTH SERVICE

Introduction:

Following the practice in previous years, this section of the report summarises the various aspects of co-operation as it affects the West Riding.

Co-operation with General Practitioners:

STANDING SUB-COMMITTEE ON CO-OPERATION:

This Committee met on four occasions and given below are the principal agenda items:

January

Vaccination and Immunisation.

(a) Vaccination against smallpox by health visitors.

(b) Ambulance and other staff.

(c) Computer Scheme.

i. Statistics—pilot areas.

ii. Payments for patients aged 16 plus.

(d) E.C.N. 682—variation of immunisation procedures.

Comprehensive Assessment Centres for Handicapped Children.

County Ambulance Service—999 calls.

Radio communication service for general practitioners.

April

M. R. C. Investigation of Measles Vaccine.

Dilution of Vaccine.

Children and Young Persons Act, 1963. Children (Performances) Regulations, 1968.

Protection of School Children against T.B. Department of Education and Science Circular 3/69.

Infective Hepatitis.

Anti-D Gamma Globulin.

July

Ordering of Ambulances.

Road Accident After Care.

County Ambulance Service Bulletin No. 402B—Sudden Illness in the Home.

Screening Tests for Phenylketonuria, using the Guthrie Blood Test Method.

Notification of Infective Hepatitis—Blood Transfusion Service.

Tattooing of Minors Act, 1969.

Review of West Riding Psychiatric Service Areas.

Rehabilitation of Drug Addicts.

October

Vaccination and Immunisation Scheme.

Measles Vaccine—Supply.

Fluoridation—latest position in the West Riding.

Day Care of Children.

Manygates Hospital, Wakefield. E. coli outbreak. 'Early Warning System'.

Guthrie Test for Phenylketonuria.

Mental Health Service. Review of Officers' duties.

Carcinogenic substances in schools and hospitals.

PREMISES FOR JOINT USE:

The number of general practitioners providing general medical services wholly or partly within the administrative area at 1st April, 1969, was 1,436 compared with 1,433 in 1968, 1,417 in 1967 and 1,490 in 1962. The percentage of general practitioners in group practice continues to increase slightly.

New buildings completed during the year were:

					Date of completion
'E' Type Health Centres:					
Birkenshaw	...	...	...	...	2nd May
Bramhope	...	...	...	...	17th February
Mytholmroyd	...	...	...	...	17th February
Mini Clinics:					
Altofts	...	...	...	...	9th January
Great Houghton	...	...	...	...	9th January
Moorends	...	...	...	...	15th January

The above list comprises four buildings with main or branch surgery accommodation for four practices comprising 16 general practitioners. At the time of writing, there is no general practitioner content in the Altofts clinic.

At the end of the year 72 practices comprising 176 general practitioners were provided with main or branch surgery accommodation in 57 health centres and clinics.

GENERAL PRACTITIONERS IN MATERNITY AND CHILD WELFARE WORK:

Participation by general practitioners in traditional public health activities is indicated below:

Employment of General Practitioners by the County Council in Infant Welfare Clinics

				Total Doctors' Sessions	General Practitioners' Sessions	Percentage of total sessions done by General Practitioners
1963	...	...	...	12,118	5,212	43
1964	...	...	...	12,492	5,496	44
1965	...	...	...	11,761	5,844	49
1966	...	...	...	11,678	6,711	57
1967	...	...	...	11,307	6,679	59
1968	...	...	...	10,762	6,285	58
1969	...	...	...	10,187	5,930	58

Employment of General Practitioners by the County Council in Antenatal/ Postnatal clinics

		Total Sessions	General Practitioners' Sessions	' Midwives only ' Sessions	Percentage of total sessions done by General Practitioners
1963...	...	3,557	1,390	323	39
1964...	...	3,253	1,267	242	39
1965...	...	3,009	1,122	258	37
1966...	...	2,693	1,123	295	42
1967...	...	2,216	920	296	42
1968...	...	2,026	893	239	44
1969...	...	1,573	776	206	49

Rent-free Infant Welfare Sessions conducted in County Clinics by General Practitioners for their own patients with the Health Visitor in attendance.

				Sessions	No. of General Practitioners involved
1963	...	...	...	Nil	—
1964	...	...	...	Nil	—
1965	...	...	...	46	5
1966	...	...	...	58	6
1967	...	...	...	50	2
1968	...	...	...	147	11
1969	...	...	...	294	21

Rent-free Antenatal Sessions conducted by General Practitioners for their own patients in County Clinics

				Sessions	No. of practices involved
1963	...	...	...	588	15
1964	...	...	...	902	25
1965	...	...	...	1,456	36
1966	...	...	...	1,643	43
1967	...	...	...	1,927	51
1968	...	...	...	2,159	53
1969	...	...	...	2,381	57

Midwives attending Antenatal Patients in General Practitioners' surgeries (outside clinics)

				Sessions attended	Midwives involved
1963	...	...	...	1,621	62
1964	...	...	...	1,945	67
1965	...	...	...	1,905	85
1966	...	...	...	3,600	105
1967	...	...	...	3,458	91
1968	...	...	...	4,380	104
1969	...	...	...	4,816	115

STAFF ATTACHMENTS:

The marked increase in the number of home nurses attached to general practitioners and the continuing trend for health visitors and midwives is shown in the following table:

Attachments of Field Staff to General Practitioners

At 31st December		No. of Health Visitors attached	No. of Home Nurses attached	No. of Midwives attached
1964	...	68	33	27
1965	...	128	47	43
1966	...	140	70	45
1967	...	153.5	115	49
1968	...	209	196	49
1969	...	205	214	49

BULLETIN FOR GENERAL PRACTITIONERS:

Health Notes and the complementary *Divisional Medical Officer's Newsletter* continued to be issued quarterly.

Co-operation with Hospitals:

MATERNITY LIAISON COMMITTEES:

Meetings were held in Bradford, Doncaster, Harrogate, Wakefield, York, Rotherham and Sheffield. Matters discussed included: gastroenteritis in infants; booking arrangements in general practitioner units; possibilities of an integrated midwifery service; introduction of the Guthrie screening test.

GERIATRIC LIAISON COMMITTEES:

These are usually held on an informal basis and are attended by the geriatrician and our field staff who meet regularly to discuss problems of mutual interest and specific cases at Airedale, Barnsley (Mount Vernon), Bradford (St. Luke's),

Doncaster, Hemsworth (Southmoor), Knaresborough, Pontefract (Headlands), Rotherham (Badsley Moor and Moorgate), Skipton and Wakefield (County General and Pinderfields) hospitals. Of recent date those at Doncaster and Wakefield (Pinderfields) have assumed a more formal basis.

MENTAL HEALTH LIAISON COMMITTEES:

Committees have been established in conjunction with Doncaster, Storthes Hall, and York Hospital Management Committees. The last two do not appear to have been notably effective due largely to our inability to meet the consultants' demands for community placement for those patients who in their opinion, are no longer in need of hospital treatment.

HEALTH VISITOR ATTACHMENT TO HOSPITALS:

Fifty-four members of staff visit 88 hospitals to co-ordinate services in relation to maternal and premature baby care; diabetic, tuberculous and elderly people; and orthopædic and pædiatric patients. Handicaps from other conditions also receive attention.

Whilst not a permanent liaison arrangement, a rota of health visitors and district nursing sisters have attended Sheffield Childrens' Hospital throughout the year to observe modern care of children with spina bifida and hydrocephalus in order to be able to help and support parents of such children.

DIVISIONAL ADMINISTRATION

The divisional scheme of administration in the County was set up in 1947 and at that time consisted of thirty one divisional areas. At the beginning of 1969 there were twenty divisions and no changes have taken place during the year. Negotiations were proceeding in the latter part of the year for the amalgamation of two divisions.

The following changes have taken place in the senior divisional staff.

Deputy Divisional Medical Officers and Senior Departmental Medical Officers

Division No. 4 (ShIPLEY)	Dr. J. P. Stuart resigned 31st July.
Division No. 11 (Castleford)	Dr. R. Chapman resigned 28th February.
Division No. 20 (Colne Valley)	Dr. A. L. J. Cusack resigned 31st August.
Division No. 23 (Hemsworth)	Dr. E. E. Cromb retired 4th October.
Division No. 23 (Hemsworth)	Dr. J. Hayes promoted 6th October.

A list of senior staff and other details concerning each division is given in Appendix A.

The co-ordination of the work of the divisions is undertaken through the work of the Divisional Medical Officers' Conferences which meet every month other than August. All major policy and its implementation is discussed at these meetings to ensure that all senior staff may make an appropriate contribution to the consideration of policy and in addition all those problems which arise in divisions are also discussed for clarification and further action.

PART III

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Prevention of Illness, Care and After-Care

Health Education

Recuperative Home Treatment

Mental Health

See also Tables 38 to 61 of Appendix A

CARE OF MOTHERS AND YOUNG CHILDREN

Dental Treatment of Expectant and Nursing Mothers and Pre-School Children:

The Chief Dental Officer reports:

EXPECTANT AND NURSING MOTHERS:

Three hundred and thirty-one expectant and nursing mothers received treatment as compared with 402 last year. This continued reduction in numbers follows the pattern of the last eight years, when free treatment became available under the National Health Service for this class of patient.

SERVICE FOR THE UNDER-FIVES:

During his visit to this Authority in June, Mr. J. G. Potter, Dental Officer of the Department of Education and Science, commented upon our rather weak service for under-fives. The difficulty here is access to pre-school children. It will be recalled that in 1966 third-birthday cards were sent to all children in four divisions in an effort to persuade parents to bring these children to their local dental clinic for examination and treatment if necessary. In nine months, 1,500 birthday cards were despatched and the number of children known to have been brought to the clinics as a result was only seven! A further period of trial produced no greater success.

More recently, clinics were instituted in the Garforth area to which mothers have been invited to bring their pre-school children for physical and developmental assessment and advantage has been taken to invite parents, whilst still on the premises, to take their children to the dental wing for examination. In the first nine months of 1969, with the co-operation of the medical staff, the dental officer saw 149 children, an average of 3.5 per session. It would seem that as 'Developmental Assessment Clinics' are instituted in other areas, increasing opportunity will present for improving this service and this is currently being explored.

Though efforts will continue to be made to bring to the notice of parents of pre-school children the need for dental examination at an early age, the one single factor which could contribute most to the dental health of these children is the fluoridation of the public water supply. Long experience abroad and more recent experience in parts of England show beyond doubt that fluoridation of water is a completely safe and certain means of ensuring a reduction in dental decay of at least fifty per cent.

Phenylketonuria:

Since 1st March, 1960, the health visiting staff have been using the 'Phenistix' test to screen babies for phenylketonuria.

In October, 1968, a circular was received from the then Ministry of Health on the results of a panel of the Working Party of the Medical Research Council on phenylketonuria, set up to study different mass screening methods for the early

detection of phenylketonuria. The report recommended that 'Phenistix' testing for phenylketonuria should be replaced by the Guthrie test, as this was the test least likely to fail to detect phenylketonuria in an affected newborn infant, thus enabling dietary treatment to start as early as possible.

The Guthrie test is done by pricking the heel of the baby and collecting several spots of blood on to specially-absorbent filter paper. This paper is sent to the laboratory where it is used to ascertain whether the baby has phenylketonuria. The test is best done between the 6th and 14th day of life.

Following this report, it was decided to try the use of the Guthrie test in two pilot areas, i.e. Castleford and Pontefract, from 1st July, 1969. The test was carried out by the midwife on the 10th day after delivery on all children born at home or born in hospital and discharged before the 6th day. In September, 1969, a memorandum was sent to all hospitals suggesting that hospital maternity departments should be responsible for screening for phenylketonuria all infants in hospital on or after the 6th day of life, the medical officer of health being responsible for the screening of babies born at home or discharged from hospital before the sixth day.

Reports from the pilot areas revealed that no serious difficulties had arisen in using the Guthrie test and it was decided in October, 1969, that the use of the Guthrie test would be introduced throughout the County as soon as the divisional medical officers could obtain laboratory services from their local hospitals. In the meantime, the health visitors would continue to use the 'Phenistix' test.

During 1969, 28,267 babies were tested either in clinics or at home during the fourth week of life, or as soon as possible afterwards, using the 'Phenistix' test.

The test gave a positive result in three cases and two of these were confirmed after hospital investigation. Details of these cases are as follows —

- Case 1 Girl, J. L., born 25.3.69.
Positive 'Phenistix' test at 3 weeks.
Admitted to hospital. Dieting began in April.
Follow-up report (February, 1970)
Strictly-controlled diet; attends hospital weekly for blood test.
Progress is normal and the expected milestones have been achieved.
- Case 2 Boy, G. P. C., born 13.8.69.
Positive 'Phenistix' test at 4 weeks.
Admitted to hospital. Dieting began 11.9.69.
Follow-up report (February, 1970)
Strictly-controlled diet; attends hospital fortnightly.
Development is normal.

Ortolani Testing for Congenital Dislocation of the Hip:

During 1969, 64 confirmed cases of congenital dislocation of the hip were discovered by hospital staff, domiciliary midwives, health visitors, clinic medical staff and general practitioners. This makes a total of 317 confirmed cases since the Ortolani test was introduced as a routine procedure in December, 1962.

Congenital Abnormalities:

Under the national scheme for the registration of congenital abnormalities discovered at birth and recorded on the notification of birth form, 455 babies with a total of 542 abnormalities were notified.

The number of births notified during the year was 30,632, giving a percentage of 1.5 for babies with one or more congenital abnormalities.

Welfare Foods:

At 31st December, 1969, there were 308 distribution centres in the County for the issue of welfare foods, of which 229 were health or child welfare centres.

As from January, 1969 national welfare foods have not been distributed through clinics in Division No. 9 which comprises the Urban Districts of Garforth, Rothwell and Stanley and the Rural Districts of Tadcaster and Wetherby. Agreement has been obtained to local chemists selling national welfare foods.

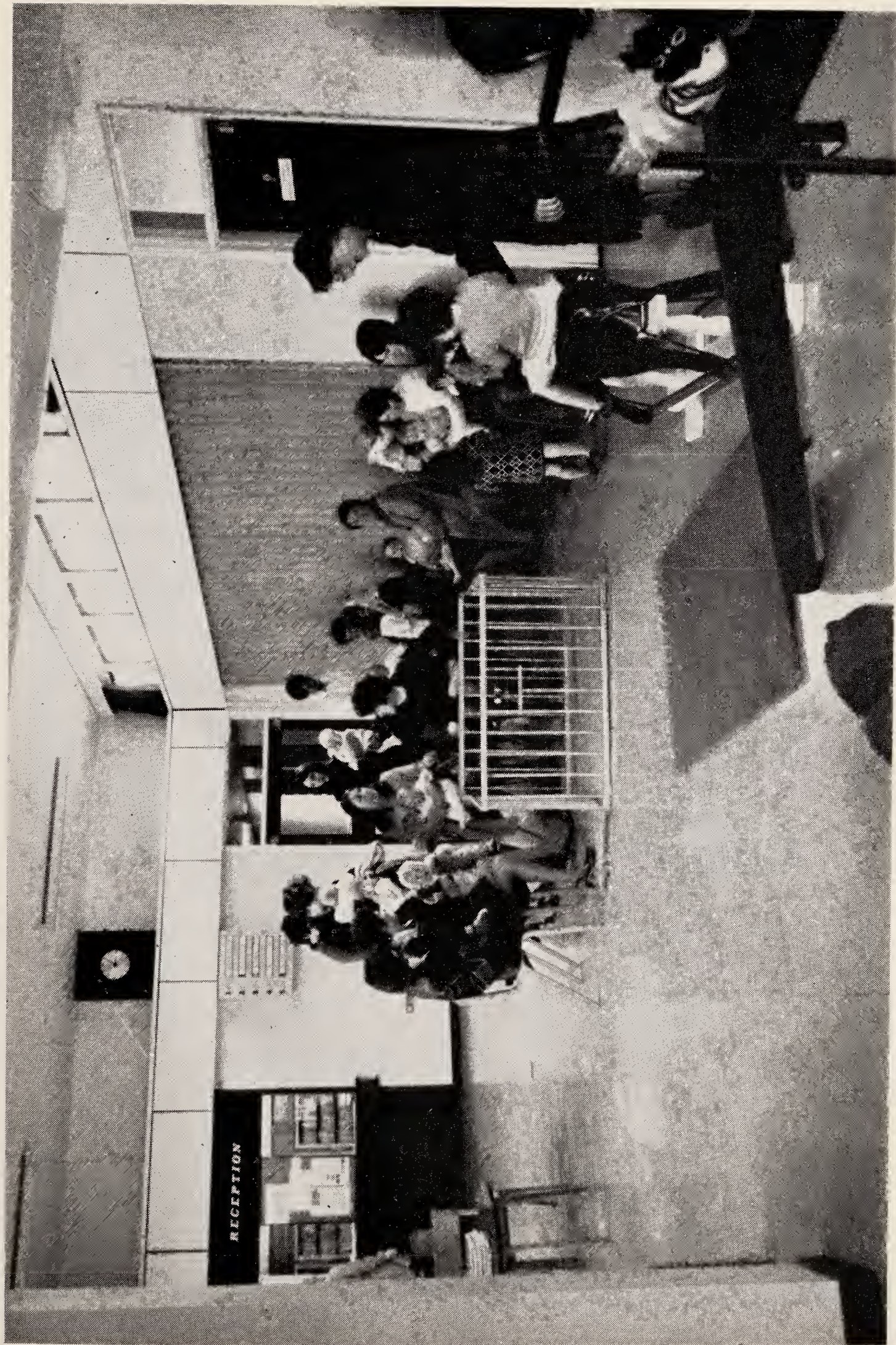
The withdrawal of the distribution of welfare foods from clinics has released health visitors for the purpose of regular developmental assessments and clerical staff for the administration of this scheme and the further development of an efficient handicapped children's register.

Children Neglected or Ill-treated in their own Homes—Prevention of Break-up of Families:

Throughout the administrative county, there were 84 meetings of the Co-ordinating Committees, established—under the chairmanship of the Divisional Medical Officer for the area—to co-ordinate the activities of the many statutory and voluntary organisations concerned in the welfare of children.

The arrangements made by the County Council to safeguard the interests of housing authorities in selected cases, where there was a danger of the families being evicted and broken-up and the children being taken into care, have continued.

The Special Sub-Committee, established to consider those cases where application for assistance had been made by housing authorities, continued to meet regularly and, at the end of the year, 136 families remained under review. The action taken by the Committee has helped to prevent the eviction of families from their homes and has enabled the work of rehabilitation to continue.



Ilkley Health Centre—in Multiple Use. G.P. and Health Education Activities



Co-operation in Casualty Care—Motorway Accident



Renal Dialysis at Home



Mental Health Training Centre—Industrial Work

MIDWIFERY

Domiciliary Midwifery:

Miss S. E. D. Stuart, Supervisor of Midwives for the past six years, retired at the end of December.

STAFF SITUATION:

The establishment is 280 whole-time midwives. In post at 31st December, 1969:

Whole-time midwives	...	...	...	...	155
Part-time midwives	...	...	...	...	10
Whole-time home nurse/midwives			...	...	43
Part-time home nurse/midwives	...	...	...		2
					<hr/> 210 <hr/>

The whole-time equivalent is 182. There were 17 appointments, 14 resignations, 10 retirements, and 1 midwife transferred to another service.

Attendances by midwives at antenatal sessions have increased from 6,372 in 1968 to 7,197 in 1969. These sessions provide opportunities for midwives to meet mothers booked for hospital confinement, who may well be discharged before the tenth day. The majority of those booked for hospital attend the local antenatal sessions for the middle trimester of their pregnancies. Mothercraft and psycho-physical preparation for parenthood continue to be important parts of domiciliary midwifery.

EMERGENCY OBSTETRIC UNITS:

There were thirty-four reported calls on this service, the large majority being concerned with difficulties in the third stage of labour.

IN-SERVICE TRAINING:

Thirty-one County midwives and six from adjoining authorities and hospitals attended a course at Grantley Hall.

Thirty midwives attended statutory refresher courses.

Since May, 1969, midwives in the Wath upon Dearne area have attended in rotation at the Montagu Hospital, Mexborough, sharing in the ward work of their hospital midwifery colleagues. This arrangement is working satisfactorily and is of value to all concerned.

MATERNITY LIAISON COMMITTEES:

See report on page 79.

HEALTH VISITING

Staff Situation:

Establishment, including 22 fieldwork instructors for student health visitor training: 	407
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In post at 31st December, 1969:

Qualified health visitors (including 22 part-time)	291
Assistants to health visitors (including 56 part-time)	112
Whole-time school nurses 	1
Whole-time tuberculosis visitors 	4
	408

Whole-time equivalent 	368
--	-----

Changes of staff during the year included:

Appointments —	Qualified health visitors	33
	Assistants to health visitors (S.R.N.)	41
Resignations —	Qualified health visitors	30
	Assistants to health visitors 	21
Retirements 		9
Transfers to health visitor training		14

Attachment to General Practices:

Two hundred and five qualified health visitors are attached to 259 practices involving 550 general practitioners. Certain areas in the County still have too few qualified staff to make attachment work satisfactorily but progress continues.

In-Service Training:

Forty-two health visitors and eighteen assistants to the health visitors attended courses at Grantley Hall.

Thirty members of field staff and five senior members attended courses outside the County.

Training in the detection of hearing loss was given to sixty members of staff at Garforth, Baildon and Cleckheaton with the co-operation of Drs. Dolton, Battersby and Douglas.

Health Visitor Training:

Twenty-four students qualified in 1968/69. Thirty-five students were accepted for the course commencing October, 1969.

Eleven fieldwork instructors attended follow-up courses and five received the full course of preparation. These members of staff will receive letters of recognition from the Council for the Training of Health Visitors.

Cars:

Three hundred and eighty-two health visitors and assistants used cars for their work of which two were provided by the County.

Statistics—Comments on Table 49:

As in the 1968 report, figures given are for first visits only and represent approximately 25 per cent. of the total visits paid.

HOME NURSING

The number of patients nursed rose by 534; 38,202 cases compared with 37,668 in the previous year.

Visits increased by 11,046 to a total of 849,084. In addition, 3,235 hours were spent in doctors' surgeries treating ambulant patients.

On the 31st December, 1969, 214 home nurses were attached to 263 practices comprising 598 general practitioners.

Staff Situation:

Three hundred and twenty-three nurses were employed at the end of 1969, four more than in 1968, and were made up as follows:

Home nurses, S.R.N. (21 part-time)	...	...	...	267
Senior relief home nurses, S.R.N.	...	...	...	1
Home nurse/midwives, S.R.N. (2 part-time)			...	44
Home nurses, S.E.N. (4 part-time)	...	...	...	10
Village nurse/midwife, S.E.N.	...	...	...	1
				<hr/>
				323
				<hr/>

The equivalent in whole-time home nurses is 287.5.

There were 40 appointments, 21 resignations, 11 retirements, and 5 transferred to other services.

Training:

Ten nurses completed the course and all were successful in gaining the National Certificate in District Nursing.

Refresher Courses:

Forty-five nurses attended a course at Grantley Hall.

Cars:

Two hundred and ninety-six home nurses and home nurse/midwives used cars in connection with their duties, 73 being provided by the Authority.

Day and Night Nursing Service:

The object of this scheme, which is provided as an extension of the Home Nursing Service, is to provide a day and night nursing service for temporary periods—usually in an emergency or during the terminal stages of illness—to afford some measure of relief to relatives who are under a considerable strain resulting from caring for patients over a long period. Trained nurses, persons with nursing experience and ‘sitters-in’ are employed in the service. Whilst this service is not one which is called upon frequently, it is one which can, nevertheless, be of immense benefit.

During the year, the service was used in fourteen divisions; 251 cases were provided with 14,218 hours of service at a cost of £4,297.

AMBULANCE SERVICES

I am indebted to Mr. V. Whitaker, O.B.E., F.I.A.O., County Ambulance Officer, for the following report and Table 52 of Appendix A.

The West Riding County Council scheme for the provision of an Ambulance Service under Section 27 of the National Health Service Act 1946 and approved by the Minister of Health, provides that the County Ambulance Officer shall be responsible to the County Medical Officer of Health but in fact, the County Ambulance Officer was in 1948 made solely responsible to the Health Committee for the administration and operation of the County Ambulance Service.

In June of this year, it was considered opportune to regularise the position, with the result that the Ambulance Officer is now responsible to the County Medical Officer of Health.

Work done by the Service during the calendar year is shown by the following statistics:

Whole Service, including:	23 Ambulance Stations, 5 St John Agencies 2 Taxi firms
and	the Hospital Car Service—

Out-patients	...	...	589,783
Admissions	...	...	62,656
Discharges	...	...	31,555
Transfers	...	...	12,869
Accident Patients	...		16,875
Hospital Car Service			9,653
Sedbergh Agency (Taxis)			1,414
			<hr/>
			724,805
			<hr/>

Total emergency patients (included in above total patients)	...	...	25,681
Total mileage	...	...	4,907,642 miles
Number of accidents attended in homes	...		5,296
Number of road accidents attended	...		4,607

During the year there has been, in some areas, an indication of rationalisation of demand on the Service by the hospitals, a main contributing factor to which is the continued and improved liaison by the Ambulance Service with the hospitals.

Whilst no further expansion of the scheme to bring all stations under the central control system has been possible until the new control building is completed, the control staff operating the eight stations under central control have been able to improve their expertise and streamline procedures.

The Authority's Training School for ambulance personnel was occupied for 46 weeks of the year, providing six 6-weeks basic courses for recruits, four 2-weeks qualifying courses and two 1-week control staff courses.

During the year, delivery began of the new Ford Transit ambulances, special features of which are that stretcher cases are conveyed positioned forward of the rear axle, thereby giving a more comfortable ride to the patients. All equipment lockers are to the rear of the patient compartment, making the equipment more easily accessible, particularly at road accidents and the lower floor than previously eases the strain of lifting when stretcher loading. These ambulances have been well received by the staff and have created much interest by other authorities and the Department of Health and Social Security.

Work has now begun on the adaptation of property at Threelands, Birkenshaw, to provide a new Headquarters, with the addition of a new building to house Central Control.

A new station to replace the old one at Todmorden was completed and work started on a new station at Gildersome to replace the Birkenshaw station and sited within easy access to the M.62 motorway now under construction.

A most gratifying feature during the year was the award of the British Empire Medal to two members of the Service, Shift Leader J. W. Forster of Bramham Station and Miss M. E. Taylor, Clerk/Telephonist at Maltby Station, both in recognition of their long and meritorious service.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

It is significant that in the discipline we know as health education, the word health precedes education. It is of even greater significance that we are increasingly talking of education for health, for the way the subject is described reflects the interest shown by the medical and teaching professions.

Health education has been, and still is, one of the tools of preventive medicine. It has been used effectively to improve the health of the mother and young child; it has helped eliminate the problem of infectious disease by improving hygiene and promoting immunisation campaigns; but although health education has been an extremely useful aid in the hands of the health worker, with today's diseases it is becoming extremely limited, for what we are now demanding is not a minor change in behaviour pattern like hand washing before food preparation but changes affecting the whole way of life of the people we are trying to help. Whilst hand washing may seem a nuisance to some sections of the community, it can hardly be described as an intolerable infringement of personal liberty, but when we ask people to give up smoking, when we ask them to stop over-eating, when we ask them not to be promiscuous we are in fact asking them to abstain from practices that they find pleasurable. There are psychological, physiological and social problems involved which are difficult to control. Health education in the past has been closely linked with the biological sciences, but more and more it is being recognised that the behavioural sciences have far more to offer in the prevention of today's major diseases. Today's health educator must be aware of the sociological and psychological factors which influence behaviour towards accepting or rejecting health advice. Of the infectious diseases, contact with the infecting agent produced the disease in a matter of days or weeks, with today's major diseases contact may be over a period of decades and it is the whole way of life that may need to be changed rather than the elimination of an infective source. It is much easier to prevent an unacceptable pattern of behaviour developing than to remedy it once it has become established; if we are to do this then we must concentrate more on education for health in school.

Too often in the past it has appeared as if schools have had two functions, to teach able pupils to jump over academic hurdles like the Eleven Plus and the General Certificate of Education and the less able pupils the rudiments of the three R's. Today, however, the aim is to teach all children education for living and this cannot be divorced from education for health. Health education in schools should no longer consist of a visit from the health worker to talk about menstruation and other 'sensitive' subjects but should embrace all aspects of health. One might even say that all education is health education.

One of the aims of health education stated by the World Health Organisation is to equip the individual with the skills, knowledge and attitudes that will enable him to solve his own health problems; if we omit the word health then we are left with a statement that sums up one of the primary aims of modern education; education and health education then become indivisible. If health education is to make further progress in the prevention of disease then health educators must take advantage of the current situation where educationalists are now eager to educate for health.

In education for health in schools, teachers will be required to take a more active part than many have hitherto done. There are encouraging signs that this is in fact happening, but there will be instances where an outside speaker, the school doctor, nurse, or clergyman, can add impact. The school doctor and nurse can become part of a team, planning and advising on the health content of subjects. As the rôle of the school doctor and nurse changes with less emphasis placed on routine medical inspections then these workers will have time to assume the rôle of adviser to the school on all health problems as they affect education.

In the West Riding, a Joint Working Party has been set up to study how best to implement health education in the schools. This Working Party consists of junior and senior school teachers, advisers of the education department, representatives from the teachers training colleges and of the health department. Unlike other joint working parties set up by local authorities, notably county boroughs, our aim has not been to produce a document which can be used as a blueprint for health education throughout the County; in an area as large and as diverse as the West Riding, it is unlikely that a uniform pattern of health education would be effective.

The Working Party has considered ways in which teachers can obtain more information on health matters. Two methods of giving information has been tried, one is by the publication of a combined journal, *Well-being*, which is circulated to all schools once a term and, in addition 'occasional papers' are produced which deal with particular topics in greater depth. Secondly, in-service training courses are held. In parallel with the progress being made in schools, advances have also been made in the teachers training colleges so that future teachers are made aware of the rôle of health education within the schools.

The health educator of tomorrow will need to co-ordinate the work of differing professions and disciplines; health education will need to be a team effort and liaison between health and education will form the basis of that team.

JOINT WORKING PARTY ON HEALTH EDUCATION:

This group met on three occasions.

The policy has been to discuss subjects on which the teachers feel that help is required. Theoretically this would seem the wrong way to approach the problem, but practical results were needed quickly so that the enthusiasm of the group could be maintained. With this in mind, the following topics were considered:

Venereal Disease.

Sex Education in Junior Schools.

Prevention of Accidents in School and First Aid.

Drugs.

With regard to venereal disease, an 'occasional paper' was circulated to all schools (copy appended); this was followed up by a one-day seminar at which 150 people attended.

The Working Party reviewed the T.V. programmes on sex education and a seminar on this subject will probably be arranged in 1970.

A short guide for teachers on first aid treatment in school is in preparation for circulation in 1970.

It is likely too that a seminar on drugs will be held in 1970.

TEACHERS TRAINING COLLEGES:

All five West Riding Colleges now hold Health Education Courses in which health department staff are involved. In some cases the health department have provided the lecturers and the colleges have followed this up with discussion groups and group projects on health subjects. Some of the project work done by the students has been of a very high standard. A typical course arranged by the health department is as follows: general introduction to health education with its relevance to today's diseases; the School Health Service; diseases of childhood; personal health; environmental control; drugs and health; smoking; health education media; and first aid in schools.

In addition, guest speakers, such as Dr. J. A. Burgess, Consultant Venereologist, talked on Venereal Diseases, and Dr. J. Todd, Consultant Psychiatrist, on Drugs. These courses have been a success and further courses are to be held in the next academic year. The teachers of tomorrow are thus given an insight of the work of another profession and co-operation in the future between the school doctor, nurse, and the teacher must surely increase.

Whilst top priority has been given to expanding health education in schools and teachers training colleges, the other 'at risk' groups in the community have not been neglected.

REVIEW OF ACTIVITIES—HEALTH EDUCATION UNIT:

Exhibitions:

In December, 1968, the health department was invited to participate in Exias 69, an exhibition of industry and agriculture at Selby Festival to commemorate 900 years, from May 17th-26th, 1969. Eleven departments of the West Riding County Council participated.

The space requested by the health department was 1,003 sq. feet but this was finally scaled down to 715 sq. feet. The theme ‘Working together for Health’ incorporated the work of the School Health Services, Care of Mothers and Young Children, Mental and Dental Service and the Health Education Service. All the stands were produced by the technician and the Training Centre at Wombwell and entailed considerable constructive and photographic work. Though the overall attendance at the festival was disappointing to the organisers the number of people who visited the health stands was considerable. Much interest was paid by the general public, a great amount of information and health education was disseminated by enthusiastic members of staff who were in attendance during the whole of the eight day period.

Displays and exhibitions for cancer education, medicines, nursing services and home safety including the electrically operated puppets exhibition have been used throughout the county in schools, health clinics, libraries and other public places. Details of exhibitions are listed below.

<i>Exhibit</i>	<i>Number of venues</i>	<i>Number of days on display</i>
Puppet Exhibition	15	137
Old Home Safety Exhibition	2	9
Key to Safety (Medicines) Display No. 1	27	118
Lung Cancer and Smoking Display	23	106

Other Displays—e.g.

Water	}	92	371
Food Hygiene			
Rats			
Ears			
Eyes			
Fireworks			

Three 16 mm. sound projectors were purchased and issued to the Morley, Spenborough and Hemsworth Divisions respectively to meet the local needs, also three ‘Technicolor’ 8 mm. projectors were obtained to meet increasing demands for loop cassette films in school and clinic work.

Other Visual Aids:

A number of sound and loop cassette films covering subjects such as child care, personal relationship, venereal diseases were pre-viewed and some acquired for the library. Additions have been made to the library of slides used to illustrate talks given by staff. Some progress was made in the photographic work of the production of a filmstrip but was limited due to the unavoidable existing pressure of work.

Triptych display boards and posters, designed and produced by the unit, were distributed to all divisions for display in clinics and other places. These covered subjects such as:

Play safe—February/March
Local Health Services—June/July
Family Health Services—August/September
Fireworks—October
Parenthood—November/December

Posters and leaflets have been distributed, the material either designed in the department or obtained from national sources such as Health Education Council, Royal Society for Prevention of Accidents and General Dental Council.

Flannelgraphs for use as visual aids have been added to the divisional stock for use in teaching.

In-Service Training:

The health education officer attended divisional health staff meetings to promote health education, to introduce new ideas and for this purpose was also involved in an in-service training course for home nurses and midwives. Numerous talks on different aspects of health were given to ambulance, police and school meals personnel, trainee teachers, students, health visitors, members of youth clubs and other voluntary organizations.

In-service training courses are invaluable in providing opportunities to develop the skills of field staff, to make available new knowledge, new developments in methodology, to stimulate enthusiasm and give encouragement.

The health education unit arranged the following:

1. Grantley Hall Residential Course—"Health Education and Child Development". Twenty-five members of staff attended.
2. Three-day study course—"Class Control—Teaching Techniques and Questioning". Dr. Clow, Divisional Medical Officer (Rotherham) kindly arranged for the use of Wickersley Clinic and the co-operation of Mr. Dodman, Headmaster, Maltby Grammar School, who made available classes of third and sixth formers. The course tutor and class demonstrator was Mr. D. Lynton-Porter, of the Health Education Council. This was the first time that the health department had held a course where a school co-operated in this way and allowed course participants to take an active part to gain valuable experience in class control. Forty members of staff including doctors, health visitors and midwives attended. This course was so successful that a similar one has been arranged for early in the new year.

REVIEW OF ACTIVITIES IN DIVISIONS:

Health education is basic to all the activities of the health department, the work being directed towards promoting, repairing and maintaining health at different consumer levels.

It is impossible to measure the amount of education for health which has been given to each household visited by all nursing and field staff, nor the amount given at informal talks to the school child during hygiene and other inspections in schools.

STATISTICS:

The number of children and adults who attended informal health education sessions are given in Table 53. The total shows an increase of approximately 4,000 on the previous year. The overall attendances at mothercraft sessions remains fairly constant though some divisions showed a decrease. A marked increase in the number of children who received information in the field of personal relationship which included venereal diseases indicated the trend that health staff have given more supplementary help to teachers on specific subjects. These facts are indicated by Dr. Cusiter, Divisional Medical Officer (Wath upon Dearne) in his report:

“Relaxation classes are held weekly at nine of the ten clinics in the division. However, to the disappointment of the midwives in charge of the classes, attendances have decreased due to the fact that seventy-five per cent. of all confinements now take place in hospital.

All secondary and comprehensive schools have some form of health education programme provided by the health visitor. The subjects include personal hygiene, mothercraft, smoking, drugs and the personal and environmental health services. In one or two schools, the head teachers have preferred that the health visitor should attend to give an initial series of lectures at which a teacher is present to take notes. In subsequent lessons, the teacher herself has developed the subjects introduced by the health visitor who has been in attendance merely as an adviser.”

Dr. Sammon, Divisional Medical Officer (Colne Valley) reports on the involvement of staff in school education programmes at Saddleworth Secondary Modern School:

“Mrs. McKenna, Health/Visitor School Nurse, in her school education programme has achieved the following in the Mothercraft Division of the Duke of Edinburgh awards. In 1969, 15 pupils received the Duke of Edinburgh Bronze Award and in 1970, to date, six pupils have received the Duke of Edinburgh Bronze Award, whilst a further 10 pupils are taking the examination for this Bronze Award and eight pupils have now received the Duke of Edinburgh Gold Award.”

Infant and junior schools are, in some areas, showing an awareness to health education as mentioned in the report from Dr. Battersby, Divisional Medical Officer (Shipley):

“Much of the school work has been done in the infant and junior schools and health visitors have been very encouraged by the invitations they have had from head teachers to go into the schools and carry through a planned syllabus on the fundamentals of healthy living.”

At the other extreme, Institutes of Further Education are places which present opportunities for talking to young adolescents and adults. This is taking place, for example, in the Harrogate area where a series of lectures on the basic needs of young children was undertaken.

Some areas report that a considerable amount of formal sessions are carried out in schools. Dr. Ireland, Divisional Medical Officer (Morley) comments:

“During 1969 health education was undertaken in every senior school in the division including the grammar schools. This meant an extension of the work of health education by the health visitors to two more schools in the senior grade and three junior schools.”

Midwives are increasingly being used in health education activities in the school as Dr. Oddy, Divisional Medical Officer (Barnsley) reports:

“Formal health education has progressed steadily throughout the year in schools, clinics and in outside organizations. Two of the domiciliary midwives have given talks to senior school girls, in conjunction with the health visitor's course of classes. It is hoped that all midwives will meet more of our future mothers in this way during the coming year.”

The spectrum of health education can, to some extent, be illustrated by the following extract reported by Dr. Armstrong, Divisional Medical Officer (Wortley):

“General health education activities were carried out in most clinics, following in the main the pattern of a monthly programme. Group discussions included hygiene, development of the baby, care of teeth, feet, home safety and diet, current topics, e.g. drug taking, sex education. The usual media of filmstrips, sound films, up-to-date posters and distribution of leaflets were used in an endeavour to teach the general public an approach to good, healthy living. Health visitors continue to discuss prophylaxis on every possible occasion, during the individual interview at clinics or during home visits. The number of mothers attending group discussion varies, according to the size of the clinic involved. The health visitors continue to promote a consciousness within the community of the necessity to good, healthy living.”

Recuperative Home Treatment:

Two hundred and forty-six applications for recuperative home treatment were received as compared with 267 in the previous year. One hundred and forty-four, 109 women and 35 men, were admitted to a convalescent home, the remaining 102 applications (41·5 per cent.) were cancelled.

MENTAL HEALTH

Training Centres:

ACCOMMODATION AND STAFF:

A list of Training Centres for the Mentally Subnormal and of the places available is given in Appendix A.

A new Special Care Unit at Maltby was completed and brought into immediate use. Work on the new Comprehensive Training Centre at Rastrick, Brighouse, continued throughout the year and extensive adaptations at the Rawcliffe Centre were commenced. Alterations to the West Ardsley Centre to provide a much needed expansion in special care facilities were also commenced during the year.

Eight members of the training centre staff successfully completed the course for the Diploma for Teachers of the Mentally Handicapped and the number of staff now holding the Diploma is approaching 50 per cent. Three girls who were appointed as Cadets in 1966 will complete the two year courses in 1970 and three who were appointed in 1967 will complete the training in 1971. The in-service training programme for the teaching staff has been maintained with three courses at Grantley Hall.

CENTRE ACTIVITIES:

Swimming:

The success of the learner swimming pool at the Rawcliffe Centre stimulated interest in other areas, particularly in the Horsforth Division where the Wharfedale Group of Round Tables raised approximately £5,000 towards the cost of a learner pool for the Horsforth Comprehensive Training Centre. The Horsforth pool is situated in the quadrangle and is fully enclosed and covered. It is equipped with male and female changing rooms and a plant room. The total cost was slightly over £6,000.

At three other centres schemes are well advanced and considerable funds already available for similar schemes. A number of centres hold regular swimming sessions by arrangements with local swimming baths or schools.

Having regard to the number of schemes under actual consideration the West Riding Health Committee decided to follow, in principle, the policy of the Education Committee in granting financial aid to swimming pool projects and will consider each case on individual merit.

Parent/Teacher Association:

These associations continue to play a most valuable role in maintaining contact between staff and parents and they are most generous in allocating

considerable sums to the benefit of the training centre patients. Some examples of the extent of their generosity are the provision of gymnastic equipment (at several centres), climbing frames, television sets, garden seats etc., also in several instances the local P.T.A. have met the full cost of an entire centre taking a full week of residential training at the seaside.

HOLIDAYS AND OUTINGS:

Approximately 150 trainees took part in a full week's holiday sponsored by the County Council. The adults spending a week at the Derbyshire Miner's Holiday Centre at Skegness whilst the juniors spent a week in a private hotel at St. Annes on Sea. In necessitous cases the cost was either fully met or subsidised by the County Council.

The Rawcliffe Training Centre again shared in a week's holiday organised by members of a local Youth Club. The Wombwell Rotary Club arranged for juniors from Wombwell Centre to have a week's holiday at Scarborough for the second successive year.

SPECIAL CARE FACILITIES:

Much progress has been made during the past 2—3 years to improve and extend the facilities for children who are severely handicapped both mentally and physically. Initially the County had nine small special care units catering for 4—6 children. Once this service was provided there was an increasing demand for places and it soon became evident that these small units would need to be upgraded and that new special care units would have to be planned on more extensive lines. The first of the new purpose built special care units was opened at Hemsworth in 1967 and a similar unit was opened at Wombwell later in the same year. These were followed by the upgrading of existing units at Horsforth and Maltby. Similar upgradings are in progress at Rawcliffe and West Ardsley. The new units are spacious, light and well ventilated, special attention being paid to hygienic floor coverings, ancillary rooms with sluices baths, toilets etc. The main area is divisible by means of screens to give separate departments for hyperkinetics, cot cases, etc., and all are provided with under floor heating and verandahs which are in full use during fine weather. The new units accommodate 12—18 patients according to the degree of handicap.

INDUSTRIAL WORK:

Since the commencement of industrial work in 1963 the volume of work has steadily increased and the total value of finished products reached the figure of £31,800 for the year ending 31st March, 1969. The value of services rendered by trainees (e.g. laundry, care of grounds, cleaning etc.) amounted to £5,400 giving a total income of £37,200. The cost of raw materials was £14,800 and payments to trainees amounted to £19,000.

Although work for the County Supplies Department continues to account for the larger proportion of the industrial output, there has been a considerable increase in the private work sector, particularly in the assembling of component parts for telephonic equipment, etc. Much of the private contract work is very suitable for the adult girls and they take pride and pleasure working on attractive pennants, chocolate boxes, Christmas crackers etc.

Increased provision for the incentive payments scheme allowed for individual payments to be increased and the total amount paid out was some £2,300 in excess of the previous year.

Mental Welfare Officers:

When the Mental Health Act of 1959 came into operation the County was divided into seven mental health areas, based on seven large hospitals for the mentally disordered, and a senior mental welfare officer was appointed to each area. It was originally envisaged that the senior mental welfare officer could provide the liaison between the mental hospital and the mental welfare officers working in the field. The co-operation between the field officer, the general practitioner and the mental hospitals has, however, worked out so well that the mental welfare officers now have a good direct relation with the hospital and do not have to rely on an intermediary. The County Council is also reaping the benefit of the secondment scheme for the training of officers and the number of trained officers is steadily increasing. With a view to retaining the trained officers in the County service a revised establishment, which offers promotion prospects has been approved by the Health Committee.

The revised scheme is based on divisional rather than hospital boundaries and allows for the ultimate appointment of a senior divisional mental welfare officer to each Health Division, increasing the number of senior appointments from 7 to 17.

Provision has also been made for a trainee grade so that staff with the necessary educational qualifications, but lacking practical experience, can be recruited and trained. This new establishment will be brought into gradual operation commencing in 1970.

In-service training continued by means of seminars and residential courses at Grantley Hall organised by Mrs. Farrow. The senior mental welfare officers continued to meet at monthly intervals throughout the year and were thus kept abreast of developments in the service at both county and national level.

Residential Accommodation—Hostels and Homes:

HEALEY CROFT HOSTEL, WEST ARDSLEY (30 subnormal adults):

This purpose-built hostel, which opened in 1965, accommodates 30 subnormal adults (15 men and 15 women). The hostel was full shortly after opening and

has operated to capacity during the past four years. Approximately half the residents are in open employment whilst the remainder attend the adjacent training centre. There were seven admissions and six discharges during 1969, but the waiting list continued to increase in size and stood at forty-one at the end of December. All applications are carefully screened by an Admission Panel and suitable applicants are added to the list. A considerable number of applicants require training centre placement and this produces a further difficulty as the associated West Ardsley Training Centre is also full and has a waiting list. This means that often a hostel vacancy can be offered only if the applicant is capable of open employment. Fourteen situations were obtained during the year, although six of these situations involved two residents only. Four situations were found for new residents and the remaining four were due to redundancies. At the end of the year fourteen residents were in employment and sixteen attended the training centre.

ZOAR STREET, MORLEY—ANNEX TO HEALEY CROFT (3 subnormal adults):

A County owned four-bedroomed terrace house, typical of the district, is let free of rent and rates to a married couple who have undertaken to accept three subnormal adults as lodgers. The house was renovated and opened as an annex to Healey Croft in November, 1968, when three Healey Croft residents (two women and one man) were transferred to this accommodation. The same three were still in residence at the end of 1969 and appeared to be well settled. The two women attend West Ardsley Training Centre and the man is in employment. The residents pay an agreed lodging allowance to the landlady who provides all the necessary household services including food, laundry, heating etc. The house is provided with a telephone so that the landlady can contact the Divisional Medical Officer or mental health staff if necessary, but apart from this there is no more oversight than would be given if the residents were in ordinary lodgings.

MEADOW BANK HOSTEL, HARROGATE (8 subnormal children):

This small purpose-built hostel is situated within the grounds of the Harrogate Training Centre. It accommodates eight subnormal children and they all attend the training centre from 9.30 a.m. to 3.30 p.m. Monday to Friday weekly. The children who are in long term residence go home for week-ends and holidays. The hostel is staffed by a Warden and Deputy Warden who take their holidays during the periods of training centre closure. There is, however, a period of approximately five weeks when the long-term children are on holiday but staff are available for duty and this period enables the hostel to be used for a number of short-stay admissions. This hostel has been full since it was opened in 1964 and there is a short waiting list. There have been four admissions and four discharges of long-stay children during the year.

THE GHYLL HOSTEL, SKIPTON (16 subnormal children):

The County Council's second purpose-built hostel for subnormal children, was opened in March, 1969. The hostel is pleasantly situated on high

ground overlooking open country and the Skipton Training Centre which is about a quarter of a mile away. Having regard to experience gained at Harrogate, this hostel was planned to accommodate 16 children with sleeping accommodation in eight two-bedded rooms. There is a Warden and two Assistant Wardens and the accommodation is so planned that there is a division of staff and children on the ground and first floors. Nine children were admitted when the hostel opened but the numbers quickly built up to capacity. Some of the children come from a considerable distance, including several from South Yorkshire. Where travelling permits children go home every week-end but children from a distance return to their homes every fourth week-end. This hostel is also available for short-stay cases at certain periods.

LEE GRANGE HOSTEL, WEST ARDSLEY (20 post-psychotic adults):

This purpose-built hostel opened in July, 1968, and by the end of the year there had been 17 admissions and eight discharges. The agreed policy is to admit patients who have completed their hospital treatment at psychiatric hospitals for short periods in order to promote social rehabilitation before return to the community. This policy necessarily involves a large turn-over of cases and during 1969 there were 30 admissions (one of whom was a re-admission) and 24 discharges. At the end of the year there were 15 residents in the hostel. There would appear to have been an increase in the use made of Lee Grange by certain consultant psychiatrists in the surrounding hospitals, possibly because of hospital visits made by members of the hostel staff. There has been an improvement in the work record of the residents due to progress in the relationship between the hostel staff and local employers. The opening of the Mirfield Day Industrial Centre will provide facilities for those residents who are unable to obtain open employment. An Admissions Panel meets at frequent intervals to consider cases awaiting admission and to review the cases in residence.

15, EAST PARK ROAD, HARROGATE (6 residents recovering from mental illness):

Early in 1969 the above-mentioned property became available and was taken on lease by the County Council. The accommodation provided six bed-sitting rooms which are let to specially selected patients who are recovering from mental illness and who have no home to accept them after hospital discharge. The residents are charged a nominal rental which was agreed by the County Land Agent. They do their own cooking and buy their own food but the house is under close supervision of the local mental welfare officers. Five of the six rooms have been occupied by the same residents since opening and the sixth room has had three different occupants. This project is meeting a real need in the Harrogate area and could be repeated elsewhere if suitable property becomes available.

FUTURE PLANNING OF RESIDENTIAL ACCOMMODATION:

Following the declared Government policy to run down the large hospitals for the mentally subnormal, there has been a hardening of attitude by hospital

authorities and by the consultant psychiatrists to requests for admission of subnormal patients to hospital where the application is largely on social grounds. Whilst it is agreed that some of the patients now in hospital, and a substantial number of those for whom application is being made, could be accommodated in hostels, there is not yet sufficient hostel accommodation to meet the growing demand.

The County Council's Capital Building Programme for the years 1970/71, 1971/72 and 1972/73 originally included provision for a further three Adult Hostels and two Children's Hostels. In view of recent developments, and the increasing difficulty in obtaining hospital placements on social grounds, it is evident that the building of hostels for the mentally subnormal will need to be speeded considerably.

Day Centres:

SNAITH DAY CENTRE:

This day centre, which is now in its fifth year, provides facilities for mentally disturbed patients to attend for full-time therapy on five days per week. Patients are selected by the consultant psychiatrist who also attends the centre weekly. There are 25 names on the register and the average daily attendance is 17. Patients are conveyed to and from the centre by ambulance and mid-day meals are provided through the School Meals Service. The work of the centre is mainly therapeutic but the original concept of simple mechanical jobs has now given way to craft instruction and some 24 types of craft and hobbies have been made available to the patients. Car washing, joinery, metal work, posters, art motifs etc. continue but avenues further afield have also been explored. Seventeen patients have been returned to full or part-time employment. Four ex-patients, now recovered and retired, still attend the centre on one day each week and this is a great encouragement to the other patients.

HARROGATE THERAPEUTIC CLUB:

The Harrogate Therapeutic Club operates on five full days per week at 13, Dragon Parade, Harrogate. Patients prepare their own mid-day meal on the premises and in the afternoons there are group discussions and many other activities including dressmaking, hairdressing, sewing etc. This club is very much appreciated by patients in the Harrogate area and the average daily attendance exceeds 20. Psychiatric cover is given by two consultants who attend on two afternoons each week.

MIRFIELD DAY INDUSTRIAL CENTRE:

The Authority purchased the former T.A. Drill Hall at Mirfield and approved a scheme of adaptations to provide an Industrial Day Centre for persons recovering from mental illness. Specialised machinery for the production of exercise books, cardboard cartons and chain-link netting has been installed. The centre will be in operation during the early part of 1970 and a full report on the working of this new centre will be included in next year's report.

Psychiatric Social Clubs:

These clubs, staffed by mental welfare officers, operate in the evenings and a full list is given in Table 58. They offer a varied programme of activities including whist drives, beetle drives, dominoes, bingo, table tennis, darts etc. In several clubs special evenings are set aside for the showing of colour slides and films. Discussion groups also play an important role in the therapy undertaken at these clubs.

Interchange visits with other clubs are arranged and members from three of the clubs combined for a week's holiday at the seaside where they were accompanied by the mental welfare officers who had made the arrangements.

Psycho-Geriatric Provision:

Included in the Capital Building Programme were proposals for the erection of a Psycho-Geriatric Hostel and Day Centre for South Yorkshire, under the provisions of Section 12, of the Health Services and Public Health Act of 1968. The Department of Health and Social Security, however, indicated that whether such projects were provided under the Health Services and Public Health Act, 1968 or under the National Assistance Act, 1948, loan consent could only be given from the allocation of money for welfare services. This would mean that the project could go forward only at the expense of the building programme for Old People's Homes.

Having regard to the situation, further negotiations with the Department of Health and Social Security are proceeding.

JOINT WORKING PARTY ON
HEALTH EDUCATION IN SCHOOLS — OCCASIONAL PAPER No. 1
VENEREAL DISEASE

The first question many of you will ask is 'Why choose venereal disease as the first subject for an occasional paper of this kind?'

Venereal disease is now the second commonest infectious disease in this country. It is more than twelve times commoner than tuberculosis, ten times as common as scarlet fever, and five times as common as whooping cough. Out of all the infectious diseases it is second only to measles.

It differs from measles however in many ways, not least of which is the severity of the complications which follow venereal disease. Secondly, unlike measles, an attack does not confer immunity from further attacks; and thirdly it is contracted through sexual intercourse (excepting congenital infections).

Venereal infection is therefore a common disease, and unless something significant is done in the immediate future, the disease may well get out of control.

In terms of actual numbers 195,352 new patients attended special clinics in England and Wales in 1968; in 1958 the corresponding number was 107,501.

The incidence in the West Riding has also increased; our figures have doubled from 1,391 cases in 1958 to 3,080 in 1968. If we consider gonorrhœa, which is one of the infections which make up the group of venereal diseases, the increase has been fourfold.

Why has this increase come about?

Mainly because of the more permissive climate regarding sex; more people are taking part in sex outside marriage, and therefore more people are at risk from catching the disease. Secondly, some of the organisms responsible for causing infection are becoming resistant to the drugs used in treatment.

Isn't this purely a medical problem?

It is predominantly a medical problem; once a person has contracted the disease he needs medical treatment. A social worker attached to the special clinic has the important and delicate task of following up the source of infection and ensuring that all contacts of the case are examined and treated if necessary.

But teachers too have a valuable part to play. The most disquieting factor in the increase of venereal disease is that much of the increase is occurring in young people. In fact in the West Riding in 1967, a third of all new cases of gonorrhœa in females occurred in teenagers, and a further third before the age of 25.

Teachers have two vital roles to play in the prevention of venereal disease.

The first is straightforward, namely to ensure that all children who leave school have a basic knowledge of venereal disease and are aware of the dangers if they indulge in promiscuous sexual intercourse.

Secondly, and this is much more difficult, teachers should try to influence the behaviour patterns of our youth, for syphilis and gonorrhœa are 'behavioural diseases'. Some would say that we have no right to attempt to do this, but can we stand back and watch our youngsters inflict on themselves what in many cases is permanent damage?

The intention of this paper is not to overburden teachers with statistics about venereal disease, but to alert them to the importance of the subject. There are many readable booklets available which will give factual information for teachers contemplating a discussion to senior pupils: some of these are listed below. There are also visual aids available to stimulate discussion.

Any teachers who want advice or help in arranging programmes can contact the Divisional Medical Officer of Health in their area, or the Working Party through the County Education or Health Departments at Wakefield.

Suggestions for further reading

"The Venereal Diseases" by Dr. R. D. Catterall.

A book published by Evans, 1967, available from County Libraries.

"Venereal Diseases" by Dr. R. S. Morton.

A Pelican paperback available from booksellers, price 3/6d. or from County Libraries.

"V.D. and Diseases Transmitted Sexually" by Dr. R. S. Morton.

Published by the British Medical Association and available from booksellers or Family Doctor Publications, 47-51, Chalton Street, London, N.W.1. Price 1/6d.

"V.D. The Facts"—a Family Doctor booklet.

Published by the British Medical Association and available from booksellers or Family Doctor Publications, 47-51, Chalton Street, London, N.W.1. Price 1/6d.

"Venereal Diseases"—O.H.E. booklet.

Published by and available from The Office of Health Economics, 162, Regent Street, London, W1R 6DD. Price 2s.

16mm Sound Films

"The Innocent Party"—Colour—18 minutes.

An American teenage boy contracts syphilis through a casual 'pick-up' and infects the girl he intends to marry. Available from Central Film Library, Government Building, Bromyard Avenue, Acton, London, W.3.

“A Quarter Million Teenagers”—Colour—16 minutes.

Deals with the physiological aspects of gonorrhœa, it is less emotional and dramatic than “The Innocent Party”. Available from Foundation Film Library, Brookland House, Weybridge, Surrey.

“The Other Side of Love”—Colour—15 minutes.

A Granada T.V. recording. Dr. R. D. Catterall, Director of the Department of Venereology, Middlesex Hospital, discusses the signs, symptoms and treatment of venereal diseases, also the work of the social worker. Available from British Film Institute, 81, Dean Street, London, W.1.

PART IV

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

See also Tables 62 to 69 of Appendix A and Appendix B

ENVIRONMENTAL HYGIENE

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

THE MILK (SPECIAL DESIGNATION) (AMENDMENT) REGULATIONS, 1965:

Licensed Dealers:

The number of dealers has remained fairly constant although there has been a slight increase in dealers in untreated and ultra heat treated milks.

It has been pleasing to see that the failure rate of the methylene blue test has declined. There is still great room for improvement with regard to untreated milk however.

Processing Plants:

There is no change to report in the number of processing plants. Extensive alterations are being undertaken at one dairy in the south of the Riding which will result in a high degree of automation.

The first automatic electronic bottle inspector in the Riding was installed in the early part of the year. The human 'spotter' we have seen so long in dairies can no longer cope with the ever increasing speeds of bottling plant so this type of equipment is virtually a necessity unless dairies are prepared to risk prosecutions for glass and other foreign bodies in milk.

It became necessary during the year to prosecute two dairies for offences. At one where a number of phosphatase failures occurred a fine of £5 was imposed plus £8 costs and at the other where a milk churn in a very rusty condition was used the fine was £5 plus £9 7s. 9d. costs.

Premises Bottling Untreated Milk:

Regular visits of inspection and supervision were made to the eleven premises where untreated milk is purchased in bulk and then bottled. Of the 143 samples obtained 19 failed the methylene blue test. Immediate follow up action was taken in each case but it is often extremely difficult to place the blame for failure between the bottler and his supplier. No sample gave a positive cream culture and only one was found to contain antibiotics.

SUPPLY OF MILK TO SCHOOLS:

Pasteurised milk is supplied wherever possible but unfortunately, by reason of their situation, a number have to take untreated milk. One hundred and twenty-three samples of untreated milk were obtained and seven of these failed the methylene blue test. Repeat samples were obtained and investigations made in each of these cases.

Untreated milk supplies to schools are examined for tuberculosis, brucellosis and antibiotics in addition to the keeping quality test. No evidence of the presence of tuberculosis was found but one sample contained antibiotics. Two samples gave positive cream cultures for brucellosis and whilst it would be ideal to find none the drop from the previous year was pleasing. Immediate notification of brucellosis is given to the divisional medical officer to enable him to stop the infected supply.

SAMPLING OF MILK AT HOSPITAL FARMS:

Sampling, which is carried out at the request of the Department of Health and Social Security, continued at two farms. At Stanley Royd Hospital Farm, Wakefield, where the production of untreated milk takes place 24 samples were obtained. Twenty-two passed the methylene blue test and two were void because of weather conditions. As the milk is not used in its raw state at the hospital but sent for pasteurisation no examination is carried out for tuberculosis or brucellosis. At Stansfield View Hospital Farm, Todmorden where milk is produced and pasteurised 24 samples were obtained. All samples passed the phosphatase test and with the exception of four void samples the remainder passed the methylene blue test.

ANTIBIOTICS IN MILK:

Two thousand seven hundred and eighty samples were examined by the Wakefield Public Health Laboratory using the modified T.T.C. provisional method for the detection of antibiotic and other inhibitory substances in milk. Twenty-six of the samples were found to contain antibiotics and action was taken in co-operation with the Milk Marketing Board.

BRUCELLOSIS:

Two thousand seven hundred and eighty samples were examined for the presence of brucellosis. All samples were submitted to the milk ring test and for cream culture and 101 gave positive cream cultures. Additionally, 137 guinea pig inoculations were carried out and this resulted in two more positive results. The total positives gave the same percentage as last year at 3·7.

The policy of notifying divisional medical officers of all results of milk samples taken by the department has continued and grateful recognition is given to them and to the county district public health inspectors for their help and co-operation.

Our thanks go again to the Directors of the Public Health Laboratories in and around the county for the useful information they continue to send us. Dr. L. A. Little, Director of the Wakefield Public Health Laboratory, and his staff, must have our particular gratitude for once more handling all the sampling work undertaken.

QUALITATIVE MILK SAMPLING:

Under the County Council's scheme of qualitative milk sampling, 111 samples were submitted to the County Analyst by county district public health inspectors. Three were deficient in fat but legal proceedings were not instituted.

FOOD COMPLAINTS:

Forty-two complaints were received and investigated. A summary is given below of the details of each case and result where legal proceedings were taken. In other cases verbal or written cautions were given.

Glass in tin of salmon.

Beetle in cornish pasty.

Discoloration of school milk by drinking straw.

Slug in bottle of school milk.

Damaged milk bottle—4 cases.

Bottle cap in milk bottle.

Glass in milk bottle—10 cases. Two prosecutions, one fined £5 with £23 1s 7d. costs and the other fined £10 with £10 0s. 0d. costs.

Foil in bottle of milk.

Cigarette end in meat pie.

Dirty milk bottle—7 cases.

Foreign matter in loaf of bread.

Nut in bottle of school milk.

Offensive smelling bottle of school milk.

Mould in wrapped milk loaf—3 cases.

Foreign matter in milk.

Milk not of normal consistency.

Frozen brussell sprouts with peculiar taste.

Bristles in school milk bottle—2 cases.

Green chalk in school milk.

Grain beetle in foodstuffs.

Mould on gooseberries.

An interesting case was discoloration of milk by coloured drinking straws. Dyes which are not permitted by the Colouring Matter in Food Regulations, 1966 had been used in the manufacture of the straws. It was found that the dairy company concerned was using old stocks manufactured before the commencement of the Regulations. Immediate steps were taken to dispose of offending straws.

Water Supplies:

PLUMBO-SOLVENT WATER SUPPLIES:

The periodical examination of water from those public supplies in the West Riding which are known, or suspected, to possess plumbo-solvent properties has been carried out.

Two samples of water were collected from each supply (a) after standing all night and (b) after standing for thirty minutes in a lead service pipe, and the samples were examined for the presence of lead. Two hundred and fifty-two samples were examined and in each case the result of the examination was notified to the medical officer of health and other appropriate officers of the county district concerned.

The W.H.O. International Standards, 1963, give 0.05 mg/l as the maximum allowable concentration of lead and all samples giving a reading above this figure are reported as being unsatisfactory. It is appreciated that the standards have no legal validity but it is hoped that all concerned with the treatment and distribution of water will endeavour to provide it to the highest possible degree of safety.

PRIVATE SUPPLIES OF WATER TO COUNTY PREMISES:

Supervision and sampling of private supplies has continued but it became apparent during the year that not all supplies were either known or being sampled. Information was sought from the Education Department and subsequently a survey commenced to enable all such premises to be brought under supervision. The survey is not yet complete but it is hoped to be recommending treatment plant quite soon in some instances.

FLUORIDATION OF WATER SUPPLIES:

It is doubtful whether any other public health measure has been the subject of so much study, research, controversy and frustration during the past quarter of a century than the fluoridation of the public water supplies. Since my Report for 1965, in which a comprehensive review was given, the overall position has changed only slightly.

During 1968 negotiations had proceeded with the Rombalds Water Board and it is pleasing to report that on the 21st January, 1969, the Water Board, in conjunction with this Authority and Bradford C.B., introduced fluoride at Reva Reservoir, Hawksworth which supplies Aireborough U.D. and the parish of Esholt in Bradford C.B. The optimum level of 1.0 p.p.m. was quickly achieved by the Water Board and subsequent independent chemicals analyses of the fluoridated water as supplied to the consumer have been carried out regularly by the Water Board, Bradford C.B., and officers of this Authority. The results have been consistently satisfactory.

Early in the year dental examinations of primary and junior school children in the fluoridated area and a control area were carried out by the school dental service to establish the prevalence of dental decay; further examinations will be conducted to assess the improvement afforded by fluoridation.

Following consideration by the Health Committee of a Resolution passed by the Programme and Budget Committee of the World Health Assembly the Clerk of the County Council communicated the decision of the Health Committee to Water Undertakers serving the Administrative County in the following terms:

Bearing in mind that dental caries is a widespread disease in many populations, and is becoming increasingly prevalent in many others;

Recalling that studies in several countries have consistently shown the prevalence of this disease to be markedly low whenever an optimal concentration of fluoride occurs naturally in water supplies;

Accepting the reports now coming from countries with experience of the procedure indicating that the adjustment of the fluoride content of water supplies to an optimal level is a practicable, safe and efficient public health measure;

Noting that other equally effective means are not available for conferring on whole populations the beneficial effects of fluoride on dental health;

Emphasizing that in the extensive scientific literature on the subject no valid evidence has been forthcoming of any ill effects on human health from the use of water supplies with an optimal concentration of fluoride;

Recognizing that several authoritative and independent enquiries conducted in a number of countries have all reached similar conclusions to the above; and

Recognizing further that for many populations the provision of potable water supplies is a first consideration.

1. THANKS the Director-General for his report;
2. RECOMMENDS Member States to examine the possibility of introducing and where practicable to introduce fluoridation of those community water supplies where the fluoride intake from water and other sources for the given population is below optimal levels, as a proven public health measure; and where fluoridation of community water supplies is not practicable to study other methods of using fluorides for the protection of dental health;
3. REQUESTS the Director-General to continue to encourage research into the etiology of dental caries, the fluoride content of diets, the mechanism of action of fluoride at optimal concentrations in drinking water and into the effects of greatly excessive intake of fluoride from natural sources and to report thereon to the World Health Assembly, and
4. REQUESTS the Director-General to bring this resolution to the attention of all Member States.

¹Document A22/P&B/7.

The response from the water undertakers, however, provided only slight satisfaction. Of the 22 water undertakers concerned, ten were in favour of fluoridation, five were against, six decided to take no action for a variety of reasons, and one, a newly created Board, had not made a decision. In regard to the ten undertakers in favour, two had made positive progress: the Rombalds Water Board whose scheme at Reva Reservoir is referred to above and who also have a further scheme at the advanced planning stage; and Huddersfield C.B. who hope to introduce a small scheme early in 1970 to serve the Borough and parts of the Administrative County, also two further small schemes in 1970/71.

In the area of the Craven Water Board there are numerous small supplies: when a new service reservoir is built and certain treatment works remodelled it may be possible to proceed with two schemes of fluoridation but these are not expected to be operative before 1971/72 or even later. Progress by the remaining seven undertakers in favour of fluoridation is held up due to other local health authorities, which these undertakers supply, being against. In one instance the position is ludicrous: over 99 per cent. of the consumers in the area of one Water Board reside in the West Riding Administrative County but from a practical point of view it is not possible to fluoridate the water supplied to them without also affecting the water supplied to consumers in the area of another local health authority. This latter authority decided that further consideration should be given to the fluoridation of water supplies in their area in three years time.

Every opportunity has been taken towards implementing the Authority's policy of fluoridation of the water supplies but in the foreseeable future it would appear that only a small proportion of the County's residents will have the undoubted benefits afforded by this proven measure.

Rural Water Supplies and Sewerage Acts, 1944-61:

All schemes submitted for grant were examined and comments forwarded to the County Planning Officer for onward transmission, with his observations, to the County Council's Consulting Engineer.

In addition, Ministry Inquiries and Investigations of Schemes were attended where held.

Local Government Act, 1958, Section 56:

SEWERAGE SCHEMES—APPLICATIONS FOR GRANTS:

No application was received during the year.

School Swimming Pools:

Details of 67 swimming pools in operation and under construction are given in Table 68.

In addition Children's Homes at Garforth, Knaresborough and Pontefract use paddling pools in the summer. None are provided with water treatment plant although they have sufficient depth for children to swim. Discussions have taken place with the Children's Department and inspection and sampling of the pools are to be carried out next year. Recommendations will then be made if necessary regarding water treatment plant.

Sampling is also carried out at the Woodhall Centre, Wetherby and Hilton Grange Children's Home, Bramhope although these are not County establishments.

The present overall total of pools is therefore 72 and during the year, 1,726 water samples were submitted to the Public Health Laboratory Service in Wakefield for bacteriological and chemical testing. The results indicate that overall satisfactory standards are being maintained.

Caravan Sites Act, 1968:

GYPSIES:

The setting up of the first site for gypsies has still not been achieved. At the end of the year a fiercely contested public inquiry was held regarding the County Council's proposals to establish a site at Baildon. A counter proposal was made by Bradford Corporation for a site on land in their ownership but within Baildon. Both proposals were strongly opposed by a local residents association and at the time of writing the Minister has not made his decision.

Further talks have been held between the County Council Working Party and all interested parties including representatives of the travelling people. Whilst as previously reported, a not unexpected reluctance to establish sites has been expressed by some local authorities it has been interesting to find that not all travellers want sites either. The idea of being on regulated sites and the attendant possibilities of having to pay taxes does not appeal to some.

Pharmacy and Poisons Act, 1933:

Two hundred and nineteen visits of inspection were made to premises listed for the sale of Part II poisons.

Tetanus Survey:

The collection of soil samples continued for a long term survey of the antibiotic resistance of strains of *Clostridium tetani*. The survey is being undertaken by the Public Health Laboratory Service.

The Riding Establishments Act, 1964:

Premises licensed by the County Council were visited at least once each. The general public health aspects of each premise were examined and a report submitted to the Clerk of the County Council. This report is considered along with a report of a veterinary surgeon and one from the County Fire Officer before a licence is issued.

Atmospheric Pollution:

The Authority's scheme for the measurement of atmospheric pollution, operated in conjunction with the Warren Spring Laboratory of the Ministry of Technology and officers of the County Districts, has continued efficiently.

At the year end 38 District Councils were participating involving 48 combined daily smoke filter and sulphur dioxide instruments, and four daily smoke filters only.

PART V

MISCELLANEOUS

Welfare of the Epileptic and Spastic

‘ Wardens ’ Schemes for the Aged

Persons in need of Care and Attention

Registration of Nursing Homes

Notification of Births

**Medical Arrangements for County Children’s Homes
and Residential Nurseries**

Medical Examination

Road Traffic Act, 1960

West Riding Distress Fund

See also Tables 70 to 74 of Appendix A

THE WELFARE OF THE EPILEPTIC AND SPASTIC

Details are given in Appendix A of all known epileptics and spastics.

The County Council's scheme under Section 29 of the National Assistance Act, 1948 for the provision of welfare services for physically handicapped persons (general classes) was inaugurated in 1953 and there are now 7,235 registered cases, a number of whom suffer from cerebral palsy or epilepsy.

The County Council administers 50 social and handicraft centres for use by all classes of the handicapped and provides domiciliary visitation by way of district welfare officers, who advise on the many personal and social problems arising from handicap, and by handicraft instructresses, who teach those who are home-bound and cannot attend centres. Additional services provided include the supply of aids on loan and adaptations carried out at the homes of handicapped persons to secure their greater comfort or convenience.

A number of grants were made during the past year to enable severely disabled persons to take a holiday and the County Council has continued its practice of contributing to the funds of voluntary organisations which promote welfare services for those suffering from epilepsy and spasticity.

'WARDENS' SCHEMES FOR THE AGED

In 1956, all County District Councils were informed that the County Council were prepared to consider the making of contributions (now made under Section 56 of the Local Government Act, 1958) towards the expenses incurred by them in the development of services for aged persons accommodated on Council estates subject to the submission of schemes containing full details of the proposals.

During the period of July, 1957, to December, 1969, 569 schemes have been approved by the County Council, affecting 83 District Councils.

Following the implementation of the West Riding County Council (General Powers) Act, 1964, the County Council informed all County District Councils that they were prepared to consider the making of contributions towards the expenses incurred by them in the development of services for aged persons living in privately owned or rented accommodation.

During the period September, 1965, to December, 1969, 390 schemes have been approved by the County Council, affecting 51 District Councils.

Under Section 119 of the Housing Act, 1957, twelve Housing Associations supervising sixteen schemes receive annual contributions in respect of accommodation for aged persons.

I am indebted to Mr. J. H. Bargh, County Welfare Officer, for supplying the above information also Tables 70 to 73 of Appendix A.

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

Section 47 of the National Assistance Act, 1948, and the National Assistance (Amendment) Act, 1951, which provide for the compulsory removal to appropriate accommodation of persons requiring care and attention had to be instituted in eleven cases: one man and six women were admitted to hospital and two men and two women to Part III accommodation.

REGISTRATION OF NURSING HOMES

There was one amended registration during the year under the provisions of the Public Health Act, 1936, as amended by the Nursing Homes Act, 1963.

NOTIFICATION OF BIRTHS

(Public Health Act, 1936, Section 203)

The number of live and still births notified and attributable to the County Area was 30,632. When this figure is compared with the Registrar General's return of 30,689 births (30,274 live and 415 still births), the degree of error is small and affords satisfactory evidence of the system of notification. Prompt notification makes it possible to arrange for early visiting of babies by health visitors, and it is satisfying to record that 30,045 first visits to children born in 1969 were made.

MEDICAL ARRANGEMENTS FOR COUNTY CHILDREN'S HOMES AND RESIDENTIAL NURSERIES

Divisional Medical officers have submitted periodic reports on the discharge of their responsibilities for the medical arrangements at County Children's Homes and Residential Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious diseases, determining the hours of rest and sleep, the general supervision of health, hygiene and diet, and the staffing of the nurseries. Routine examinations, which are undertaken monthly in residential nurseries and six-monthly in children's homes, reveal the not-unexpected high proportion of children with physical and mental defects and with emotional problems.

MEDICAL EXAMINATION

During the year 2,144 Health Questionnaires were received from applicants for admission to the Superannuation Scheme either as new appointments or as admissions after two years service as manual workers. Of this number 1,493 persons were admitted to the Scheme on the basis of the information contained in the Health Questionnaire and 651 were referred for medical examination. The reasons for referral were:

	No. referred		Approved		NOT Approved		Decision Deferred	
Age	176	(224)	164	(206)	1	(10)	11	(8)
History	261	(303)	201	(251)	18	(11)	42	(41)
Category (of employment, i.e., driver)	133	(83)	123	(83)	4	—	6	—
Age and History	69	(75)	42	(50)	13	(15)	14	(10)
Age and Category	3	—	3	—	—	—	—	—
History and Category	8	(15)	8	(10)	—	—	—	(5)
Age, History and Category	1	(1)	1	(1)	—	—	—	—
TOTALS ...	651	(701)	542	(601)	36	(36)	73	(64)

(1968 figures shown in brackets)

These examinations have been carried out by the County Council’s medical officers and general practitioners employed on a sessional basis. In addition, 23 examinations have been carried out at the request of other local authorities.

Special medical examinations have been undertaken in respect of 114 employees in the various departments who have had lengthy period of sickness absence.

ROAD TRAFFIC ACT, 1960—SECTION 100(6)

The Clerk of the County Council referred 77 cases for advice with regard to their medical fitness to hold driving licences. Enquiries and investigations were carried out and appropriate recommendations passed to the Clerk for the guidance of the Local Taxation Officer.

Twenty-three persons who had been investigated previously were reviewed.

Reason for Referral	Number of cases	Number who received driving licence
Epilepsy	40	14
Diabetes	3	3
‘Blackout’ (ætiology unknown)	4	1
Vision	3	1
Mental illness or } Sub-normality	8	7
Cardio-vas. disease	10	6
Other Physical Disabilities	7	4
Other (withdrawn)... ..	2	—
TOTAL ...	77	36

WEST RIDING DISTRESS FUND

Grants from the West Riding Distress Fund were used to provide assistance for mentally subnormal persons: in one case bedding was provided, and in another financial aid was given to enable a subnormal man to visit hospital. Additionally the kennel fees for a dog of a mentally-ill woman were paid.

PART VI

THE HEALTH OF THE SCHOOL CHILD

**The Annual Report of the Principal School
Medical Officer**

including

**The Report of the Principal School
Dental Officer**

See also Tables 75 to 87 of Appendix A and Appendix C

THE HEALTH OF THE SCHOOL CHILD

(Being the 62nd Annual Report of the Principal School Medical Officer)

Introduction:

The future of the School Health Service has been the subject of much discussion of late. Concern was expressed by many of its personnel that no mention of it was made in the first 'Green Paper' on the future of the health services. This omission was corrected in the second Green Paper although its future organizational pattern is likely to change in the coming integration of the health services.

Sir George Godber, the Chief Medical Officer of the Department of Education and Science, in *The Health of the School Child, 1966-68* on page 4 of the Introduction wrote:

"There are those who would say that the school health service is approaching its end; they are people without understanding. It is approaching a period of greatly enhanced opportunity closely united with the health provision for children as a whole."

The Council of the School Health Service Group of the Society of Medical Officers of Health has devoted much time during 1969 to a discussion of the future rôle of the service and the need to look to wider developments. The views of the Council have been circulated to all principal school medical officers in the country as well as to other professional bodies. Dr. Simpson Smith, as current President of the Group, was a member of the working party and the views expressed coincide with the efforts being made in the West Riding to re-vitalize the service in the light of current developments.

Two of the main points made were the need for close co-operation with all agencies dealing with children and the need for in-service training of the staff to fit them for a more specialised rôle.

The four principal medical officers in the health department work as a close team and much work is taking place on schemes for developmental assessments for the pre-school child so that much more information on the child will be available at school entry. A joint working party on health education with a preponderance of educational representatives, has resulted in a wider dissemination of information to assist teachers in planning health education programmes in the schools. Various joint meetings between the Health and Education Departments have continued to stimulate close liaison between the services.

The course for departmental medical officers from October, 1968—July, 1969, mentioned in last year's report proved to be a great success and was followed by a shorter introductory course for newer recruits to the service held from October to December, 1969. Plans are now being made to introduce short courses on specific aspects of the work with handicapped children.

Difficulties in staff recruitment still persist although there has been a slight improvement in the number of speech therapists employed. A national working party has been set up to discuss the problems of further recruitment, training, and duties of the therapists and evidence has been submitted to the appropriate organizations.

Much preliminary work has been carried out with a view to compiling a record of handicapped children on the computer. This will facilitate record keeping and follow-up of the cases.

The report deals in a little more detail with certain aspects of the work. Once again I wish to record my appreciation of the co-operation of all concerned in the care of the schoolchild and the continued growth of the team spirit between all the agencies concerned.

Care of Handicapped Children:

A working party has been set up within the department to consider ways of improving the techniques involved in the early recognition of handicaps. From information received from birth records, health visitors' comments when completing the immunisation consent form or when screening hearing in infancy it is possible to prepare two lists: (a) children having handicaps from early infancy, (b) infants who may be 'at risk' of showing subsequent handicaps from relevant factors in the maternal or birth history. At the age of 18 months it is intended that all the children on the two lists should be screened as some of the defects present at birth, e.g. club foot may have been treated successfully and have no residual defect. By this age it should also be possible to decide if the children 'at risk' are showing evidence of handicap. Children with relevant handicaps will then be followed up at appropriate intervals during the pre-school years.

In addition simple tests of child development have been prepared so that the nurse can complete them at appropriate ages and refer on for more detailed examination infants who appear to be retarded or showing other abnormalities. These children will be investigated in more depth by the medical staff. In-service training courses are being developed for both nursing and medical staffs to give them guidance on this relatively new field of 'developmental paediatrics'.

Screening the hearing of infants is now an established procedure and more attention is being devoted to the assessment of vision in the pre-school child to prevent such conditions as squint or short-sightedness being missed. Special training courses are also being planned in this sphere. An eye defect unrecognized until the child enters school can result in educational difficulties due to lack of binocular vision.

These procedures will be facilitated by the use of the computer. A complete list of handicapped children can be built up throughout the pre-school and school period and, at a later stage, information will be more readily available to the

County Welfare Services and County Careers Officers on children requiring help on leaving school.

More detailed assessments in the pre-school period will enable more information to be given to the educationalists on children who will require special help either in the ordinary schools or at special schools. Some of the problems of the physical handicap 'spina bifida cystica' are dealt with in a separate article in the report. Following earlier studies plans have now been made for an increased number of day schools for physically handicapped children in the Yorkshire area. Further day schools for educationally subnormal pupils are being opened each year in the West Riding and it is hoped to have a further residential school for maladjusted boys in 1972.

The Child with Impaired Hearing in the Ordinary Schools:

Detailed reference was made to the work being carried out in this sphere in the report for 1968. Further extension of the services of the peripatetic teachers of the deaf is proposed during 1970 but it will be some years before all areas can be provided with this specialized help as there is still a shortage of appropriately trained teachers.

The 'Clumsy' Child:

Further studies are being carried out on the incidence of clumsy children in ordinary schools. Certain pilot studies have been undertaken and will be repeated but about 2 per cent. of school children show marked evidence of inco-ordination for various reasons and a further 4-5 per cent. show some evidence of the syndrome. Unless these children are recognized they may be labelled as 'dim' and become frustrated by educational failure with poor writing etc. An article in *Well-being* in March, 1969 drew special attention to these children. Diagnosis is important as once the condition is recognized the child can often be helped in the ordinary school situation. Those more severely handicapped may improve dramatically following a period of admission to a remedial centre with the more individual help available.

Remedial Centres:

There has been some confusion on the rôle of remedial centres in the past and some educationalists have taken the view that remedial centres are providing help which should be available in the ordinary school. Whilst ideally this is true and there have been examples of teachers attempting to 'dump' their dull children on to the centres there are a number of children with more specific handicaps who are likely to fail in the large classes within the normal schools.

After prolonged discussions various guide lines have now been laid down and periodic case conferences are held at all the centres with teachers, medical officers, psychologists and educational administrators attending. More detailed investigations of potential pupils are carried out to select those most likely to benefit from admission to the centres. The final selection is in the hands of the head of the centre.

The main types of children considered are:

- (a) Children with specific learning disabilities including the 'clumsy' child.
- (b) Children showing early maladjustment associated with adverse environmental and social conditions who are failing in school.
- (c) Children with I.Q's in the 75-90 category who have specific emotional problems but who are not regarded as frankly maladjusted.

Priority is given to children from the age of seven years rather than the older age groups as early help often results in a return to the ordinary school after a short period at the centre. The centres do not cater for children over the age of eleven years.

Only a small number of centres are operative at the present time. Others may be opened as premises become available.

The Maladjusted Child:

THE CHILD GUIDANCE SERVICE:

Some changes of staff have taken place during the year. The medical staff now consists of three consultant psychiatrists (part-time) seconded by the Leeds and Sheffield Regional Hospital Boards; two senior medical officers in psychiatry employed by the authority, and three senior departmental medical officers with a special interest in the emotional problems of childhood. In addition a number of departmental medical officers attend at some of the clinics and assist in the work. Each year members of the medical staff are seconded on short in-service training courses so that they can give more help in the early recognition of emotional problems.

THE EARLY DETECTION OF MALADJUSTMENT IN SCHOOL CHILDREN:

Mrs. Pilkington (Psychologist), Dr. Armstrong (Divisional Medical Officer) and Dr. Clarke (Departmental Medical Officer) have carried out a pilot study on a 'screening' procedure based on a questionnaire to teachers in an endeavour to pick out emotionally disturbed and educationally subnormal children at the commencement of their junior school education. Their preliminary findings have been published in *The Medical Officer* (1970, 123, 55). Further surveys will be carried out but the questionnaire will probably be of considerable value. Other surveys have also been undertaken on the identification of the 'clumsy' child and early recognition of educational failure. These 'screening' procedures should enable one to pick out many of the children with emotional problems before frank 'maladjustment' has become established.

THE WORK OF THE PSYCHIATRISTS:

Dr. Elizabeth Gore reports as follows on the operation of the Child Guidance Clinic at Harrogate:

“In 1969, 139 new cases were seen—90 boys, 49 girls, of whom 120 were referred from Division 7 as follows:

	Boys	Girls	Total
Divisional Medical Officer	28	16	44
General Practitioners	17	12	29
Head Teachers	12	2	14
Parents	5	8	13
Pædiatrician	2	2	4
Speech Therapist	1	2	3
Teacher of the Deaf	1	1	2
Probation Officer	2	—	2
Children's Department	1	—	1
National Children's Home	2	1	3
N.S.P.C.C.	1	—	1
Others	4	—	4
	76	44	120

As the figures show there has been an increase of 35 cases this year, and an overall increase of girls (the number being doubled). The general impression of the cases seems to suggest that the girls have been referred because of parental concern in many cases, and also that there was a preponderance of secondary school girls.

We therefore broke down the figures to study these two points. Four of the girls have been referred for psychological assessment only, but of the remaining 45, 28 were over eleven years of age, and of these 28, in 14 cases the parents had initiated the referral through the general practitioner, or divisional medical officer.

Since the most frequent age of referral for boys has remained between eight and eleven, these findings seem significant and may suggest an increased concern on the part of the parents in the development of their adolescent girls. The general increase in the number of cases seen may be attributed to an increase in staff, rather than an increase in referrals, since we have always had a waiting list.

We have continued to have visits from students from Ripon Training College; The Institute of Education, Leeds; departmental medical officers etc. These have meant that lunch-time discussions have been taking place regularly both on Thursdays and Fridays.

Contact with health visitors has continued, to discuss individual cases, but so far it has not been possible to extend this to the idea of a regular consultative service.”

Reporting on the Child Guidance Clinics at Mirfield, Pontefract, Ossett and Morley, Dr. Maxwell states:

“The numbers of first attendances at the clinics for which I am responsible have continued to show the steady increase noted in the previous years. However, it has been possible to eliminate the waiting list at the Mirfield and Ossett Clinics. A short waiting list has been accomplished at Morley by increasing the work of the clinic beyond its normal capacity. The situation is less satisfactory at Pontefract where the waiting list has been reduced to about three months. Again a number of lectures have been given to interested organisations and members of the public health medical staff have attended the clinics.

Table 1

	<i>Mirfield</i>	<i>Ponte- fract</i>	<i>Ossett</i>	<i>Morley</i>	<i>Total</i>
No. of sessions held... ..	196	98	47	47	388
No. of new cases	161	88	28	40	317
No. of cases continuing at- tendance from previous years	92	57	23	36	208
No. of cases closed during 1969	151	84	27	30	292
No. of cases carried forward to 1970	102	61	24	46	233

Table 2

		<i>Number of New Cases</i>					
<i>Clinic</i>		<i>1964</i>	<i>1965</i>	<i>1966</i>	<i>1967</i>	<i>1968</i>	<i>1969</i>
Mirfield	...	115	106	104	165	164	161
Pontefract	...	75	67	41	74	74	88
Ossett	...	9	15	20	17	24	28
Morley	...	10	19	31	32	32	40
Rothwell	...	27	37	28	—	—	—
				(to 7-10-66)			
Total	...	236	244	224	288	294	317''

Dr. Orme, Consultant Psychiatrist at the Swinton, Barnsley and Ecclesfield Clinics raises an interesting aspect of mothers entering training courses. He reports as follows:

“An interesting clinical observation is that at each of these clinics, we are treating one or more children whose mothers are receiving some form of professional training as mature student teacher, student nurse etc. and who have been accepted for training by Education or other Authorities after the onset of the children’s difficulties. It can, of course, be argued that these mothers would find difficulty with their children whether they were training for professional work or not. Students however, may have to concentrate more on their training than a qualified person, and thus there is even less time for attention

to the children. We do find too that the training programmes impose considerable limitations on the time the mother is able to give to her child's treatment and frequently this is given as the reason for not attending the clinic. We often wonder if the benefit to the community of having these people trained justifies the expenditure of time and money in trying to relieve the difficulties of the children. Certainly it seems desirable that training establishments accepting married women should enquire very carefully into the probable effects on the family of the mother's attention to her new work."

He also refers to the fact that, with the present services, many children requiring help are not being reached.

"Above all, thought must be given to the problems of helping the children who are not yet reached by the present services. Surveys continue to show that only one fifth of children who could be helped are known to child guidance services, so the aim should be a five fold expansion. What this means in terms of staff and building provision is left to the future, but it cannot be said that the service is satisfactory until this is tackled. On the other hand, it may be possible that the increasing interest in schools in 'counselling' and helping pupils' total development may call for clinic staff to come out of the clinics and do much more work actually advising and guiding teachers on their own ground.

Close co-operation with child care officers and with probation officers has been maintained. There is no doubt that these social workers consider that the child guidance clinic workers have special skills."

THE WORK OF THE PSYCHOLOGISTS:

Mention was made in last year's report of the establishment of psychologists in the West Riding being below the national average. The situation is being reviewed in the light of the increased spheres of work being undertaken as the following report demonstrates.

There was a considerable extension and broadening in the range of psychological work during 1969, made possible by an increase in staff, there being eight full-time and one part-time psychologists employed in the service throughout the year. The most significant improvement was in psychological work in the ordinary and special schools and in assistance in various ways with remedial education, almost twice as much time being given to work in the schools as in the previous year. Many more children with handicapping conditions and specific learning problems were examined. At the same time, full participation in the team work of the child guidance clinics continued, and more maladjusted children were seen by the psychologists. For the first time, about equal attention could be given to the three main areas of psychological work, in the clinics, in the schools, and in clinical assessment of handicapped children.

The following figures compared with those for 1968, show in numerical terms the main extensions in work.

	1969	1968
Total children seen	1,714	1,146
Maladjusted children seen in child guidance clinics ...	753	578
Children with other handicaps	961	568
Visits to ordinary schools	796	431
Visits to special schools	152	58

Work in Child Guidance Clinics:

All the psychologists were attached to child guidance clinics, some of the clinics having the assistance of two psychologists. At some clinics, especially those which have a training function, virtually all children referred for child guidance were seen by the psychologist; at others, only selected children were seen for psychometric examination. In one area, the psychologist had sufficient time outside clinics to be available for assistance with the screening and selection of maladjusted children for child guidance attendance.

Figures are given in the Appendix regarding the 753 maladjusted children seen for psychological examination in the child guidance clinics.

The proportions of children in the different symptom categories remained about the same as previous years, with 62 per cent. being classified as behaviour problems, and about 25 per cent. as nervous conditions. There was the usual majority of boys, 530 boys compared with 223 girls.

Age trends in children referred for child guidance are worth recording in view of the emphasis being placed on early detection and treatment. The proportion of pre-school children remained the same as in 1968, at about 2·5 per cent., as too did the 40 per cent. of children over the age of 11 years when first referred. There was a slight increase in children aged 5 to 7+ years, the percentage for 1969 being almost 25 per cent. compared with about 20 per cent. the previous year. This may or may not represent a real movement in the direction of more efficient detection of emotional disturbance in the early years of schooling. But there were indications several years ago that not more than 16 per cent. of the children then coming to child guidance clinics were below the age of 8 years, while about 50 per cent. were of secondary school age.

An experiment was carried out in Division 22 using a short adaptation of the Rutter questionnaire for the screening of maladjusted children in their schools at the age of 7 and 8 years, and it is intended to continue its use, with the expectation that emotionally disturbed and educationally retarded children may be detected earlier in their school careers.

Although the clinics receive referrals from all agencies, screening is necessary. During 1969, about 64 per cent. of referrals came from schools and school medical officers, about 20 per cent. from family doctors, and almost five per cent. from parents themselves. Other agencies, such as probation, the courts, and child care, referred relatively few children.

Work in the Schools:

The increase in psychological work in the schools is reflected, although not fully represented, by the increase in school visits. It is becoming possible in some areas for the psychologists to visit schools regularly, mainly to discuss child guidance cases; but this frequently leads to requests for other assistance which there is not the time to give. The requests are mainly for help in the assessment of children with learning difficulties, and in certain areas and particular schools, there is obviously a very large demand for psychological assistance which cannot be met.

One psychologist, together with the school medical officer and social worker, was able to attend regular conferences held at two comprehensive schools and to be available at clinics held in the schools. Some of the child guidance clinics have established a tradition of lunch time conferences, frequently attended by head teachers and school staff, as well as by other professional workers. Other aspects of school psychological work, not given in the statistics, were started during the year. Group assessments of children in certain schools, where head teachers had requested it, or where selection for remedial education was important, were undertaken in some areas; and a survey was made of the progress of hearing impaired children in the Keighley schools. A group screening procedure was carried out in the Shipley Division to identify educationally handicapped children in the final infant year, the work being undertaken by the psychologists attached to the Shipley clinic and the head of the remedial centre, and involving 202 children, in all the infant schools in the division. The progress of these children is being systematically followed up. A report on this work which indicated an incidence of backwardness of about 13 per cent., with 4 per cent. requiring consideration for remedial attention, and just short of 1 per cent. special schooling, was prepared in September. Psychologists are now working closely with the remedial centres which clearly have a specialised function, particularly in helping emotionally disturbed and mildly handicapped children with learning difficulties, and which need to take suitably selected children.

Special Schools:

For several years, the psychologists have visited the residential special schools for review and re-assessment of particular children. Every child who enters Bridge House School, for example, is seen by the psychologist attached to that school on entry or soon after, and periodically re-assessed. Such coverage is not possible or necessary at other residential special schools; but the work continues to grow.

Some of the day special schools are requesting further help from the psychologists; and regular visits were arranged with some of them. At one day school for the e.s.n. regular diagnostic sessions were started by the psychologist, with staff participating in observation of diagnostic procedures and discussion of the findings. Staff in this field of education are in the vanguard so far as remedial techniques are concerned, and this presupposes an understanding of and familiarity with particular psychological diagnostic procedures.

Reading Disability:

This remains the major educational problem in the children we see. It is a serious additional handicap in about a fifth to a quarter of maladjusted children referred to child guidance clinics. The problem still remains, in child guidance practice, of children being referred at an age when the disability has become chronic. Detection of reading failure, with investigation of the failing child, should be possible after two to three years in school; and it should not be necessary to initiate full investigation after five or more years of failure.

Work with Children with other Handicaps:

Their close association with the school health service has enabled the psychologists to take part easily in the assessment and guidance of children suffering from the whole range of physical, sensory and mental handicaps, often at a very young age. This work has steadily increased. Of the 961 children with specific handicaps examined during the year, 362 were generally backward, many of them having severe mental handicaps, and this compares with 207 children in this category seen during the previous year. Although the psychologists have had relatively little direct contact with the training centres, they have seen large numbers of children subsequently admitted to them.

Of children with physical and sensory handicaps, it is the hearing impaired whom we have most frequently been asked to see, 98 hearing impaired children being examined during the year. We saw more children with motor handicaps during 1969, this being partly due to the increasing interest in the problem of the 'clumsy' child, who frequently has additional educational problems.

The greatest increase in work was in the examination of children with specific learning disabilities, 359 children with such difficulties being seen during 1969, compared with 160 the previous year. The statistics indicate the particular proneness of boys to learning difficulties in school, outnumbering girls by 272 to 87. Most of these children were referred during the middle school years. Such children are found in all schools, irrespective of the type of area served by the school, or of the social background from which the children come. We are aware, from discussions with headteachers, that many more children could be seen for psychological investigation if staff were available.

It is to be expected that children with conspicuous handicaps will be detected early in life. This is reflected in the fact that over 10 per cent. of handicapped children were of pre-school age when seen for psychological examination. About 84 per cent. of the handicapped children were referred to psychologists by the schools and school medical officers, the remainder being referred mainly by pædiatricians, family doctors, parents themselves, speech therapists and the peripatetic teacher of the deaf.

Two of the psychologists continued to attend the audiology clinics in Otley and Doncaster.

Summary:

The work undertaken has expanded considerably and has become well distributed between work in child guidance clinics, which is a necessary base for inter-disciplinary contacts, discussion, and training; in the ordinary and special schools, and in the area of diagnosis and guidance with the whole range of handicaps in children. There is some flexibility in the work undertaken by psychologists, this depending on local needs and facilities, and to some extent on the particular interests and training of each psychologist. Time has been found for some research of immediate practical relevance, and most of the psychologists have been involved in lecturing to courses and giving talks to various organisations. There are obvious points of growth, with some demands for additional help, but particularly in the schools; and future needs for psychological assistance could be anticipated particularly with deprived children and children in trouble, and with the mentally handicapped.

Minor Ailment Clinics:

The number of children treated for minor ailments continues to decline. One thousand, six hundred and fourteen children were seen; in 1968, 1,775.

Medical Examination of Entrants to Training Colleges:

In connection with their application for entry to training colleges, 2,138 students were medically examined by the departmental medical officers, compared with 2,100 for the year 1968 and 1,920 for the year 1967.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 678 children were examined by the departmental medical officers to determine their fitness for employment. The figures included children taking part in entertainments. No child was found to be unfit.

Examinations may be selective for those children known from previous medical examinations or from information given by headteachers to have had some previous defect.

Consultant Cardiac Clinic:

Dr. Hepple reports as follows on the Cardiac Clinic at Harrogate:

“Twenty-two sessions were held at the cardiac clinic at irregular intervals throughout the year. During this time 118 children made 137 attendances. Numbers of children fell in spite of the fact that 16 new cases were recommended by the family doctors and three cases were transferred from the pædiatric clinic. Eight older children were returned to the care of their own doctors and seven were transferred to the adult cardiac clinic at the Harrogate Hospital. Six children were referred to the cardiac unit in Leeds for further investigation.

It is hoped in the coming year that purely cardiac cases attending the pædiatric clinic will be transferred to this special children's cardiac clinic.”

THE SCHOOL DENTAL SERVICE

Staff:

On 31st December the full-time dental staff in post and the authorised establishment were as follows:

	Staff	Authorised Establishment
Chief Dental Officer	1	1
County Orthodontist	1	1
Dental Specialist	1	1
Senior Clinical Dental Officers ...	4	5
Area and Senior Dental Officers ...	16	18
Dental Officers	30	43
Dental Auxiliaries	5	10

Additionally, there were four part-time dental officers contributing the equivalent of 1.7 dental officers.

It is pleasing to report, for the first time in seven years, an increase in staff. This was foreshadowed by the exceptional interest of students at the Leeds Dental School in a course of lectures on public dentistry given by the Chief Dental Officer. In fact, seven graduates joined the staff; five in April, one in October and one in November, all of whom are still with us. It must be acknowledged that of staff recruited directly from dental school, a number are trying their wings and past experience teaches that some of these will be lost to more lucrative general practice in due course. However, so long as they remain with us every effort is made to appraise them of the interesting and rewarding, if not always financially, aspects of children's dentistry.

Dental Auxiliaries:

The Annual Report for 1968 anticipated the relaxation of the strict supervision required by the General Dental Council for dental auxiliaries. As from the 1st September, 1969, in the light of the experience, skill and reliability of each auxiliary, the degree of supervision required is left to the discretion of the Chief Dental Officer, though the work to be carried out must continue to be prescribed and checked on completion. Prior to this date, in the event of a supervising dental officer being absent on account of illness or having to be at another clinic where there was no second surgery in which the auxiliary could work, or having to carry out a school inspection, his auxiliary was obliged to cease clinical work. In such circumstances an experienced auxiliary is now permitted to continue working.

While this relaxation is welcomed, attention is drawn to comments in the Annual Report for 1967 on the short-stay of auxiliaries. Of the twenty-three employed some time by the Riding, nine have left in less than one year, seven in less than eighteen months, and only four have served in excess of two years.

In view of the fact that almost without exception these ladies come to us direct from training and require some time to settle and acquire experience, the majority are only just becoming of real value when they leave, usually to return to the south to which they have become attached during their training. It is hoped that, if a training school is sometime in the future established in the north, some of this difficulty will be resolved.

Course in Diploma in Dental Public Health:

Two dental officers have been authorised to attend a course at the Leeds University leading to the Diploma in Dental Public Health. The course is part-time and is spread over three academic terms. This post-graduate qualification was introduced specifically for dental officers intending to make a career in the Public Dental Service and it is thought that in the future it may assume similar importance to the Diploma in Public Health in the Health Service.

Clinics:

A dual-surgery purpose-built dental wing in the health centre at Ecclesfield was completed and in operation in October. Treatment for this area was formerly provided from a mobile unit with the attendant difficulty of providing general anæsthetics and treatment of an extended nature.

Inspection and Treatment:

Twenty three thousand, three hundred and eighty-four sessions have been devoted to treatment, 1,709 more than in the previous year; this increase being due to improvement in staffing. 14,779 more children were inspected at school; 22,558 more fillings were inserted and 2,156 more full courses of treatment provided. Also pleasing to record is a small drop in the number of permanent teeth extracted, however a 20 per cent. increase in the number of deciduous teeth extracted continues to reflect a continuing staff shortage. So long as this continues and fluoridation of water supplies is denied to the public, so long must priority be given to the permanent dentition. This overall increase in fillings and extractions is attributable to an increase in output per session of almost 9 per cent.

The Laboratory:

It was with regret that the death of the Chief Technician, Mr. J. O. Ford, was reported on 1st July. Mr. Ford occupied this post from the inception of the laboratory in 1939 and was involved in its growth and development throughout his service.

The post has been filled by the promotion of Mr. Battersby, the former Technician-in-Charge.

Continuing difficulty has been experienced in recruiting experienced technicians and there seems little alternative other than to train our own. To this end, the number of apprentices has been increased from two to four.

Health Education:

During the year Mr. Metcalfe, the Area Dental Officer in charge of dental health education, held dental health campaigns in and around the areas of Mirfield, Harrogate and Knaresborough when talks and demonstrations on the care of teeth were given to nearly 14,000 children.

Invitations to speak on oral hygiene were received from schools in Rothwell, Pudsey, Wickersley and Goole, from playgroups in Harrogate and from young wives' groups in Grenoside and Horbury and from a parent-teacher association in Guiseley. A dental health exhibit was erected and manned at Selby during 'Exias 69', an exhibition to celebrate the nine hundredth anniversary of the Abbey. In July, Yorkshire Television produced a film entitled 'A Visit to the Dentist.' This was shot in the dental wing of the Ilkley Health Centre and subsequently broadcast to five-year-old school children in October as one of a series in 'My World.'

Fluoridation of the public water supply having been implemented in Aireborough in January, an incidence of caries survey has been carried out. Children aged three, five and fifteen years have been examined and the first full effect of fluoridation of the water supply throughout life will be evident in the three-year old group in the 1972 survey.

Visit of Dental Officer of the Department of Education and Science:

Mr. J. G. Potter, Dental Officer of the Department of Education and Science visited the West Riding from 25th to 27th June, during which time he reviewed the service as a whole and inspected ten clinics.

Following upon Mr. Potter's visit, a letter from the Department commends the Authority "for continuing to provide a high quality service" with an exceptionally comprehensive range of treatment and a particularly successful orthodontic service, well organised dental health education programme and an overall satisfactory output of work.

In approving the re-equipping of the orthodontic surgery at the Central Clinic, comment is made regarding poor accommodation and waiting room furnishings in some of the older clinics inherited from former Part III authorities and impossible to bring up to modern standards. Efforts, however, have been made to improve waiting rooms.

Orthodontics:

Report of Mr. Thompson, County Orthodontist:

1969 followed a similar pattern to the previous two years. Over 5,000 patients are receiving this special form of dental treatment and during the year 1,301 new cases were commenced, 1,076 cases completed, 2,534 removable appliances fitted and 93 fixed appliances fitted. These figures are satisfactory as numerous difficulties were encountered during the year.

Mr. Sanderson, who is engaged full-time in orthodontics, was also absent through illness for a large part of the year, and it became difficult to ensure continuity of treatment for orthodontic patients because of staff changes. Most orthodontic cases take approximately two years to complete and once appliance therapy is commenced it is essential that the patient be kept under skilled supervision, otherwise treatment may be unsuccessful.

A demonstration was given for the fourth successive year at the annual meeting of the Sheffield and District Orthodontic Study Circle.

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Table 1 Summary of Principal Vital Statistics, 1890—1969

Year	Live Birth Rate	Stillbirths per 1,000 total births	Death Rates							
			All Causes	Infective and Parasitic Diseases	Tuberculosis, Respiratory	Tuberculosis, Other Forms	*Respiratory Diseases	Cancer	Maternal Mortality per 1,000 total births	Infant Mortality
1890-1909	28.9	†	16.7	1.89	1.19	0.52‡	3.20	0.77‡	†	147
1910-1919	22.5	†	14.5	1.26	0.84	0.41	2.58	0.98	†	112
1920-1929	20.2	†	12.4	0.56	0.68	0.25	2.08	1.20	†	82
1930-1939	15.5	46	12.1	0.30	0.48	0.13	1.24	1.46	4.70	62
1940-1949	18.1	31	12.2	0.16	0.39	0.09	1.43	1.73	1.95	47
1950-1954	15.7	25	11.9	0.09	0.19	0.03	1.23	1.89	0.82	31
1955-1959	16.3	23	11.7	0.06	0.09	0.01	1.23	1.92	0.49	26
1960	16.9	22	11.5	0.06	0.06	0.01	1.15	1.98	0.73	22
1961	17.2	20	12.1	0.05	0.06	0.00	1.44	1.98	0.27	25
1962	17.8	18	12.0	0.04	0.05	0.01	1.47	2.00	0.20	23
1963	18.2	19	12.0	0.04	0.06	0.01	1.52	1.94	0.45	23
1964	18.5	18	11.5	0.04	0.05	0.00	1.35	2.02	0.40	22
1965	18.2	16	11.5	0.04	0.04	0.00	1.28	2.07	0.16	21
1966	18.0	14	12.1	0.03	0.05	0.00	1.62	2.00	0.25	20
1967	18.0	15	11.2	0.03	0.03	0.00	1.29	2.08	0.22	19
1968	17.6	14	11.6	0.04	0.03	0.01	1.60	2.14	0.09	18
1969	16.9	14	11.6	0.05	0.03	0.01	1.60	2.10	0.20	19

* Combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis and influenza.

† Figures not available.

‡ This rate is for the 10 years 1900-1909.

Table 2 Causes of Stillbirth

Cause and I.C.D. number	Number of stillbirths	Rate per 1,000 total births
Congenital anomalies (740-759) 	70	2 28
Chronic and acute disease in mother (760, 761) 	10	0 33
Maternal toxæmia and infection (762, 763) 	46	1·50
Difficult labour (764-768) 	24	0 78
Other complications of pregnancy and childbirth (769) ...	50	1·63
Conditions of placenta (770) 	86	2·80
Conditions of umbilical cord (771) 	41	1·34
Birth injury (772) 	4	0·13
Hæmolytic disease of newborn (774, 775) 	19	0·62
Anoxic and hypoxic conditions NEC (776) 	13	0·42
Immaturity unqualified (777) 	7	0 23
Other conditions of fœtus or newborn (778) 	4	0·13
Fœtal death of unknown cause (779)... 	41	1 34
All causes (740-779) 	415	13·52

Table 3 Perinatal Mortality, 1959-69

	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Perinatal mortality (per 1,000 total births) 	33·7	35·9	34·2	31·5	31·1	30·0	27·3	25·1	26·1	25·0	23 7
Infant deaths at 1 week and over (per 1,000 total births)	10·2	8·5	10·1	9·9	10·1	9·5	9·0	8·8	8·1	7·5	8 5

Table 4 Causes of Infant Mortality

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All causes	172	140	59	80	81	41	573
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (740-759)	24	27	16	18	14	12	111
	Total causes mainly of prenatal and natal origin other than congenital malformations (760-778)	144	98	14	2	—	—	258
	Chronic and acute disease and infection in mother (760-763)	5	1	—	—	—	—	6
	Difficult labour (764-768)	—	1	—	—	—	—	1
	Other complications of pregnancy and childbirth (769-771)	21	5	—	—	—	—	26
	Birth injury (772)	8	14	3	—	—	—	25
	Hæmolytic disease of newborn (774-775)	6	5	—	—	—	—	11
	Anoxic and hypoxic conditions NEC (776)	56	45	3	—	—	—	104
	Immaturity, unqualified (777)	47	21	5	—	—	—	73
	Other conditions of foetus or newborn (778)	1	6	3	2	—	—	12
Postnatal Group	Total causes mainly of postnatal origin	2	10	27	52	63	27	181
	Enteritis and other diarrhoeal diseases (008, 009)	—	1	5	5	13	2	26
	Meningococcal infection (036)	—	—	—	1	—	3	4
	Other infective and parasitic diseases (remainder 000-136)	—	—	4	1	2	—	7
	Meningitis (320)	—	3	—	2	1	—	7
	Influenza (470-474)	—	—	—	1	—	—	1
	Pneumonia and bronchitis (480-486, 490-492)	—	6	13	27	28	11	86
	Other diseases of the respiratory system (remainder 460-519)	1	—	3	11	15	4	33
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E911-E913)	—	—	—	—	—	—	—
	Other violent causes (remainder E800-E999)	1	—	1	3	2	5	11
Unclassified	Other remaining causes	2	5	2	8	4	2	23

Table 5 Infant Mortality, 1901-69—Rates per 1,000 live births

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
1901-1910	128	135	1966	19	20
1911-1920	100	109	1967	18	19
1921-1930	72	80	1968	18	18
1931-1940	59	61	1969	18	19
1941-1945	50	50			
1946-1950	36	40			
1951-1955	27	29			
1956-1960	23	25			
1961-1965	21	23			

Table 6 Infant Mortality, 1965-69

	Number of Deaths					Deaths per 1,000 Live Births				
	1965	1966	1967	1968	1969	1965	1966	1967	1968	1969
<i>Male Infants—</i>										
Under 4 weeks ...	255	226	237	233	210	15.6	14.2	14.5	14.5	13.4
4 weeks—3 months ...	56	57	44	41	42	3.4	3.6	2.7	2.5	2.7
3—6 months ...	39	36	42	41	48	2.4	2.3	2.6	2.5	3.1
6—12 months ...	35	38	23	31	23	2.1	2.4	1.4	1.9	1.5
Total under 1 year ...	385	357	346	346	323	23.6	22.4	21.2	21.5	20.7
<i>Female Infants—</i>										
Under 4 weeks ...	183	171	176	146	161	12.1	11.0	11.6	9.6	11.0
4 weeks—3 months ...	34	25	40	35	38	2.2	1.6	2.6	2.3	2.6
3—6 months ...	23	46	24	34	33	1.5	3.0	1.6	2.2	2.3
6—12 months ...	27	24	21	16	18	1.8	1.5	1.4	1.1	1.2
Total under 1 year ...	267	266	261	231	250	17.6	17.1	17.2	15.3	17.1
<i>All Infants—</i>										
Under 4 weeks ...	438	397	413	379	371	13.9	12.6	13.1	12.1	12.3
4 weeks—3 months ...	90	82	84	76	80	2.9	2.6	2.7	2.4	2.6
3—6 months ...	62	82	66	75	81	2.0	2.6	2.1	2.4	2.7
6—12 months ...	62	62	44	47	41	2.0	2.0	1.4	1.5	1.4
Total under 1 year ...	652	623	607	577	573	20.7	19.8	19.2	18.5	18.9

Table 7 Neonatal Mortality, 1963-69

		Number of Deaths							Deaths per 1,000 Live Births						
		1963	1964	1965	1966	1967	1968	1969	1963	1964	1965	1966	1967	1968	1969
Under 1 day	...	231	203	200	191	188	199	172	7.5	6.4	6.4	6.1	6.0	6.4	5.7
1—6 days	...	159	196	163	152	161	139	140	5.2	6.2	5.2	4.8	5.1	4.5	4.6
1—4 weeks	...	71	88	75	54	64	41	59	2.3	2.8	2.4	1.7	2.0	1.3	1.9
Total under 4 weeks		461	487	438	397	413	379	371	15.0	15.4	13.9	12.6	13.1	12.1	12.3

Table 8 Percentage contribution of the five principal cause groups of death to all causes, 1965—69

Cause Group						1965	1966	1967	1968	1969
Circulatory diseases except cerebro-vascular disease	...	...	...	...	...	38.5	37.1	37.9	37.3	37.7
Malignant neoplasms	...	...	...	...	...	17.8	16.6	18.6	18.4	18.0
Cerebrovascular disease	...	...	...	...	...	15.6	15.5	15.4	15.2	14.6
Diseases of respiratory system	...	...	...	...	...	11.2	14.3	11.6	14.3	14.6
Accidents, suicide and violence	...	...	...	...	...	4.7	4.7	4.9	4.5	4.6
Total	...	...	...	...	...	87.7	88.1	88.4	89.7	89.5

Table 9 Principal Causes of Death, 1969

Cause of death		Age at death										75 and over	Total
		Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75		
B.	1 Cholera ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	2 Typhoid fever ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	3 Bacillary dysentery and amebiasis ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	4 Enteritis and other diarrheal diseases...	6	1	8	—	—	—	1	—	—	4	4	1
B.	5 Tuberculosis of respiratory system ...	—	20	—	—	—	—	3	5	9	22	11	44
B.	6 Other tuberculosis including late effects	—	—	—	—	2	—	5	2	4	9	2	50
B.	7 Plague ...	—	—	—	—	—	—	—	—	—	—	—	24
B.	8 Diphtheria ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	9 Whooping cough ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	10 Streptococcal sore throat and scarlet fever ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	11 Meningococcal infection ...	—	4	1	—	—	—	—	—	—	—	—	6
B.	12 Acute poliomyelitis ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	13 Smallpox ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	14 Measles ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	15 Typhus and other rickettsioses...	—	—	—	—	—	—	—	—	—	—	—	—
B.	16 Malaria ...	—	—	—	—	—	—	—	—	—	—	—	—
B.	17 Syphilis and its sequelæ ...	—	—	—	—	—	1	—	—	—	—	—	1
B.	18 All other infective and parasitic diseases	4	2	—	1	1	—	4	5	3	4	1	9
	Total—Infective and Parasitic Diseases excluding Tuberculosis ...	10	27	9	2	1	1	5	7	7	11	9	28
B.	19(1) Malignant neoplasm, buccal cavity, etc.	—	—	—	—	1	2	—	4	12	20	17	89
B.	19(2) Malignant neoplasm, oesophagus ...	—	—	—	—	—	—	2	9	26	31	38	56
B.	19(3) Malignant neoplasm, stomach ...	—	—	—	—	—	2	11	33	107	143	161	106
B.	19(4) Malignant neoplasm, intestine ...	—	—	—	—	—	2	21	45	121	164	206	457
B.	19(5) Malignant neoplasm, larynx ...	—	—	—	—	—	3	27	100	6	15	10	559
B.	19(6) Malignant neoplasm, lung, bronchus ...	—	—	—	—	—	2	26	68	263	334	144	34
B.	19(7) Malignant neoplasm, breast ...	—	—	—	—	1	2	9	33	88	81	69	871
B.	19(8) Malignant neoplasm, uterus ...	—	—	—	—	—	—	—	2	41	28	32	335
B.	19(9) Malignant neoplasm, prostate	—	—	—	—	—	—	—	2	10	38	67	143
B.	19(10) Leukæmia ...	—	—	2	10	8	2	1	12	20	42	22	117
B.	19(11) Other malignant neoplasms ...	—	—	2	10	14	20	51	90	246	303	220	119
B.	Total—Malignant Neoplasms	—	—	4	20	24	33	148	399	940	1,199	986	956
B.	Benign neoplasms and neoplasms of unspecified nature ...	2	—	1	2	2	1	8	10	20	15	6	67
B.	21 Diabetes mellitus ...	—	—	—	—	1	3	1	8	25	62	72	172
B.	22 Avitaminoses and other nutritional deficiency ...	—	1	—	—	—	—	—	—	3	3	2	9
B.	46(1) Other endocrine, nutritional and metabolic disorders ...	1	1	3	8	1	3	1	2	11	11	15	57
B.	23 Anæmias...	—	—	—	2	1	—	1	—	4	10	21	39
B.	46(2) Other diseases of blood and blood forming organs ...	—	—	—	1	—	—	—	3	1	1	3	9
B.	46(3) Mental disorders ...	—	—	2	—	—	1	1	3	4	2	24	37
B.	24 Meningitis ...	3	4	1	2	—	1	—	1	—	4	3	19
B.	46(4) Other diseases of nervous system and sense organs ...	1	6	5	2	2	7	13	17	37	43	48	181

Table 9 Principal Causes of Death, (continued)

Cause of death	Age at death											Total
	Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	
B. 25 Active rheumatic fever	—	—	—	—	—	—	—	—	—	—	—	—
B. 26 Chronic rheumatic heart disease	—	—	—	—	—	—	—	—	—	—	—	—
B. 27 Hypertensive disease	—	—	—	—	—	—	—	—	—	—	—	—
B. 28 Ischaemic heart disease	—	—	—	—	—	—	—	—	—	—	—	—
B. 29 Other forms of heart disease	1	1	—	—	—	—	—	—	—	—	—	—
B. 30 Cerebrovascular disease	—	—	—	—	—	—	—	—	—	—	—	—
B. 46(5) Other diseases of the circulatory system	—	—	—	—	—	—	—	—	—	—	—	—
Total—Diseases of the Circulatory System	1	1	—	—	—	—	—	—	—	—	—	—
B. 31 Influenza... ..	—	66	9	2	8	19	165	563	1,654	3,358	5,101	10,870
B. 32 Pneumonia	20	—	—	—	5	3	6	11	20	64	50	162
B. 33(1) Bronchitis, emphysema... ..	—	—	—	—	6	4	13	40	104	301	717	1,280
B. 33(2) Asthma	—	—	—	—	—	1	12	57	262	525	465	1,323
B. 46(6) Other diseases of the respiratory system	—	—	—	—	—	—	—	—	—	—	—	—
Total—Diseases of the Respiratory System	3	30	8	—	4	2	2	9	5	9	4	38
B. 34 Peptic ulcer	23	97	18	5	19	13	41	128	414	949	1,320	3,027
B. 35 Appendicitis	—	—	—	—	1	—	3	9	29	55	61	158
B. 36 Intestinal obstruction, hernia	—	—	—	—	—	—	2	2	1	3	5	19
B. 37 Cirrhosis of liver	3	1	2	—	—	—	—	4	12	21	47	90
B. 46(7) Other diseases of digestive system	—	—	—	—	—	—	5	7	17	24	13	67
B. 38 Nephritis and nephrosis	1	2	—	2	1	3	8	18	21	49	74	179
B. 39 Hyperplasia of prostate	—	—	—	4	2	5	6	5	23	28	27	100
B. 46(8) Other diseases of genito-urinary system	—	—	—	—	—	—	—	—	3	14	27	44
B. 40 Abortion... ..	—	1	1	—	4	3	1	5	20	31	64	130
B. 41 Other complications of pregnancy, childbirth and puerperium	—	—	—	—	—	1	—	—	—	—	—	1
B. 46(9) Diseases of skin and subcutaneous tissue	—	—	—	—	3	1	1	—	—	—	—	5
B. 46(10) Diseases of the musculoskeletal system	—	—	—	—	—	—	—	—	—	—	—	—
B. 42 Congenital anomalies	—	—	—	—	1	—	—	1	—	3	2	7
B. 43 Birth injury, difficult labour, and other anoxic and hypoxic conditions	67	44	13	6	10	2	2	3	13	20	48	89
B. 44 Other causes of perinatal mortality	130	—	—	—	—	—	—	—	—	—	—	163
B. 45 Symptoms and ill-defined conditions... ..	126	2	—	—	—	—	—	—	—	—	—	130
BE. 47 Motor vehicle accidents	—	1	—	—	—	—	—	—	—	—	—	128
BE. 48 All other accidents	—	1	15	27	79	30	20	22	26	28	24	272
BE. 49 Suicide and self-inflicted injuries	1	11	24	18	23	21	19	30	38	74	174	433
BE. 50 All other external causes	—	2	—	—	10	22	27	27	51	31	14	182
Total—Accidents, Poisonings, Violence (External Causes)	3	14	41	46	118	80	71	95	129	141	226	964
Total—All Causes	371	202	102	106	201	182	493	1,302	3,409	6,096	8,334	20,798

Table 10 Cancer Mortality, 1964—69

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Mal- ignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total All Sites
1964	M.	259	589	2	—	893	64	1,807
	F.	205	96	321	163	816	53	1,654
	T.	464	685	323	163	1,709	117	3,461
1965	M.	298	723	1	—	877	56	1,955
	F.	212	104	301	165	800	46	1,628
	T.	510	827	302	165	1,677	102	3,583
1966	M.	236	667	3	—	896	46	1,848
	F.	216	116	320	163	795	45	1,655
	T.	452	783	323	163	1,691	91	3,503
1967	M.	283	707	8	—	925	49	1,972
	F.	186	109	313	158	868	49	1,683
	T.	469	816	321	158	1,793	98	3,655
1968	M.	254	713	1	—	969	65	2,002
	F.	212	141	348	151	889	58	1,799
	T.	466	854	349	151	1,858	123	3,801
1969	M.	272	742	3	—	922	74	2,013
	F.	185	129	332	143	906	45	1,740
	T.	457	871	335	143	1,828	119	3,753

Table 11 Mortality from Respiratory Diseases, 1964—69

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
1964	37	905	1,184	215	2,341
1965	25	911	1,120	191	2,247
1966	174	1,135	1,488	216	3,013
1967	10	930	1,156	185	2,281
1968	110	1,259	1,267	305	2,941
1969	162	1,280	1,323	262	3,027

Table 12 Maternal Mortality, 1965-69—Rates per 1,000 total births

Cause of Death	1965		1966		1967		1968		1969	
	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales
Maternal sepsis (not associated with abortion) ...	—	0·03	0·06	0·02	0·06	0·02	0·03	0·04	0·03	0·15
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·03	0·05	0·13	0·04	0·12	0·05	0·03	0·04	0·07	
Other complications of pregnancy, childbirth and the puerperium ...	0·13	0·11	0·03	0·13	0·03	0·10	0·03	0·10	0·07	
Abortion (with or without mention of sepsis or toxæmia) ...	—	0·06	0·03	0·06	—	0·04	—	0·06	0·03	0·04
Total Maternal Mortality...	0·16	0·25	0·25	0·26	0·22	0·20	0·09	0·24	0·20	0·19

Table 13 Mortality from Violent Causes, 1963—69

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	All other external causes	Total Accidents, Poisoning, Violence
1963	254	329	223	207	6	1,019
1964	314	299	213	196	15	1,037
1965	301	284	188	176	8	937
1966	295	293	200	186	13	987
1967	315	266	170	189	15	955
1968	277	238	151	177	82	925
1969	272	260	173	182	77	964

Table 14 Mortality from Home Accidents

Cause of Death		Age at Death—Years							
		Under 1	1-4	5-44	45-54	55-64	65-74	75 and over	All ages
Accidental poisoning by solid and liquid substances ...	M.	—	3	2	3	3	—	—	11
	F.	—	—	3	4	3	1	—	11
Accidental poisoning by gases and vapours	M.	—	—	—	1	1	2	3	7
	F.	—	1	1	—	2	2	2	8
Accidental falls	M.	—	1	—	3	3	11	23	41
	F.	1	3	2	—	3	20	97	126
Accidents caused by burns and scalds	M.	—	—	—	2	1	2	1	6
	F.	—	—	—	—	2	6	9	17
Inhalation of food or vomit ...	M.	4	—	—	—	1	—	—	5
	F.	4	—	—	—	—	2	—	6
Accidental mechanical suffocation	M.	1	6	2	1	1	—	—	11
	F.	2	1	—	—	—	—	—	3
Other and unspecified accidents	M.	—	—	3	1	—	1	—	5
	F.	—	—	—	—	1	1	1	3
Total	M.	5	10	7	11	10	16	27	86
	F.	7	5	6	4	11	32	109	174

Table 15 Suicides

External Agent		Age at Death — Years								
		Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75 and over	All ages
Domestic gas poisoning ...	M.	—	2	6	7	4	7	4	3	33
	F.	—	—	1	1	3	5	—	1	11
Other poisoning	M.	—	2	7	6	5	13	8	—	41
	F.	—	4	2	4	8	14	8	2	42
Hanging or strangulation ..	M.	—	1	—	1	1	4	3	3	13
	F.	—	—	1	—	—	1	1	—	3
Drowning	M.	—	—	1	2	4	1	3	2	13
	F.	—	—	1	3	2	4	2	—	12
Firearms	M.	—	1	1	1	—	—	—	—	3
	F.	—	—	—	—	—	—	—	—	—
Cutting instruments	M.	—	—	—	—	—	1	—	—	1
	F.	—	—	—	—	—	—	—	—	—
Jumping before or lying in path of moving vehicles	M.	—	—	—	1	—	—	—	—	1
	F.	—	—	—	—	—	—	—	1	1
Jumping from high places ...	M.	—	—	—	—	—	1	—	—	1
	F.	—	—	—	1	—	—	—	1	2
Other agents	M.	—	—	1	—	—	—	1	—	2
	F.	—	—	1	—	—	—	1	1	3
Total—All Agents ...	M.	—	6	16	18	14	27	19	8	108
	F.	—	4	6	9	13	24	12	6	74

Table 16 Child Mortality, 1911—69

Cause of Death	Annual Averages for Quinquennia							1965	1966	1967	1968	1969
	1911-15	1927-31	1935-39	1945-49	1950-54	1955-59	1960-64					
Measles	439	107	27	10	4	2	2	—	2	1	2	—
Whooping cough	167	67	29	11	5	1	<1	—	—	1	—	—
Diphtheria	110	47	51	5	1	—	<1	—	—	—	—	—
Other infective and parasitic diseases, excluding tuberculosis	54	45	18	7	9	7	3	5	3	3	3	1
Tuberculosis, respiratory ...	47	13	5	4	1	—	<1	—	—	—	—	—
Tuberculosis, other	201	82	37	30	11	2	<1	—	—	—	—	—
Cancer	3	5	4	4	9	9	11	16	16	12	12	4
Heart and circulatory diseases	4	3	2	1	—	1	1	1	1	1	—	—
Influenza	6	43	10	4	2	2	<1	—	1	—	1	—
Pneumonia	457	321	121	42	19	14	14	16	15	16	12	9
Bronchitis	150	42	10	9	6	6	6	1	4	2	—	—
Other diseases of respiratory system	49	15	6	3	2	2	1	2	1	3	9	9
Diarrhoea and other digestive diseases	248	45	38	17	4	4	5	3	6	7	5	8
Congenital debility, malformations	12	9	7	12	13	12	11	4	14	8	13	13
Accidents	82	54	50	38	27	23	27	21	27	24	28	39
Other causes	323	119	52	30	23	12	22	20	18	12	8	19
All causes	2,352	1,017	467	227	136	97	107	89	108	90	93	102
Death rate per 1,000 living in the age group	17·13	10·62	5·09	2·23	1·29	0·99	0·97	0·75	0·90	0·74	0·76	0·83

Table 17 Notification of Infectious Disease, 1964-69

Disease	Number of corrected notifications					
	1964	1965	1966	1967	1968	1969
Measles	14,385	18,175	17,567	13,528	15,291	3,392
Dysentery	432	934	630	357	691	476
Scarlet fever	1,201	1,568	1,353	1,145	794	1,053
Diphtheria	9	—	—	—	—	—
Acute meningitis	‡	‡	‡	‡	8	48
Acute poliomyelitis (paralytic)	3	4	—	—	1	—
Acute poliomyelitis (non-paralytic)	—	1	—	—	—	—
Acute encephalitis (infective)	2	1	3	5	3	1
Acute encephalitis (post-infectious)	2	1	—	3	1	—
Leptospirosis	‡	‡	‡	‡	—	—
Paratyphoid fever	6	18	1	1	1	2
Typhoid fever... ..	1	1	—	—	1	—
Food poisoning	114	82	68	56	204	109
Tetanus	‡	‡	‡	‡	—	—
Infective jaundice	‡	‡	‡	‡	473	756
Whooping cough	1,494	360	651	1,805	591	181
Anthrax	—	—	2	—	—	—
Leprosy	‡	‡	2	—	—	—
† Malaria	1	—	—	1	—	2
Ophthalmia neonatorum	5	1	3	5	2	2
Smallpox	—	—	—	—	—	—
Yellow fever	‡	‡	‡	‡	—	—
Tuberculosis:						
Respiratory	423	357	355	275	299	268
Other forms... ..	73	72	68	47	46	36

†All the cases were believed to be contracted abroad.

‡Figures not available.

Table 18 Notification of Infectious Disease, 1969

Numbers originally notified	Measles (excluding rubella)		Dysentery		Scarlet fever		Diphtheria		Acute meningitis		Acute Poliomyelitis			
	M	F	M	F	M	F	M	F	M	F	Paralytic		Non-paralytic	
											M	F	M	F
Total (All ages)	1,707	1,692	296	289	516	527	—	—	29	18	—	1	—	—
Final numbers after correction														
Under 1 year	99	92	23	14	—	7	—	—	1	3	—	—	—	—
1— „	213	222	20	20	6	7	—	—	3	—	—	—	—	—
2— 4 years	232	233	26	19	24	27	—	—	1	2	—	—	—	—
3— „	235	217	18	15	34	21	—	—	—	—	—	—	—	—
4— „	255	247	20	9	51	52	—	—	1	1	—	—	—	—
5— 9 „	590	601	62	65	252	294	—	—	7	3	—	—	—	—
10—14 „	32	30	16	11	113	76	—	—	2	4	—	—	—	—
15—24 „	15	20	8	23	22	18	—	—	4	1	—	—	—	—
25 and over	6	4	38	51	4	12	—	—	11	4	—	—	—	—
Age unknown	26	23	6	12	16	17	—	—	—	—	—	—	—	—
Total (All ages)	1,703	1,689	237	239	522	531	—	—	30	18	—	—	—	—

Numbers originally notified	Acute encephalitis				Leptospirosis		Paratyphoid fever		Typhoid fever		Food poisoning	
	Infective		Post-Infectious									
	M	F	M	F	M	F	M	F	M	F	M	F
Total (All ages)	1	—	—	—	—	—	3	—	—	—	265	206
Final numbers after correction												
Under 5 years	1	—	—	—	—	—	—	—	—	—	9	6
5—14 years	—	—	—	—	—	—	1	—	—	—	3	2
15—44 „	—	—	—	—	—	—	—	—	—	—	15	14
45—64 „	—	—	—	—	—	—	1	—	—	—	7	5
65 and over	—	—	—	—	—	—	—	—	—	—	2	11
Age unknown	—	—	—	—	—	—	—	—	—	—	33	2
Total (All ages)	1	—	—	—	—	—	2	—	—	—	69	40

Numbers originally notified	Tetanus		Infective jaundice		Whooping cough	
	M	F	M	F	M	F
Total (All ages)	—	—	397	362	90	89
Final numbers after correction						
Under 1 year	—	—	—	—	13	15
1— „	—	—	3	2	13	15
2— 4 years	—	—	24	23	35	35
5— 9 „	—	—	131	117	19	20
10—14 „	—	—	78	74	8	2
15—19 „	—	—	32	26	1	—
20—24 „	—	—	28	28	—	—
25—34 „	—	—	51	45	—	4
35—44 „	—	—	21	11	—	—
45—54 „	—	—	13	4	—	—
55—64 „	—	—	5	12	—	—
65—74 „	—	—	3	8	—	—
75 and over	—	—	2	6	—	—
Age unknown	—	—	4	5	1	—
Total (All ages)	—	—	395	361	90	91

Table 19 Measles—Incidence and Mortality, 1956—69

Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)	Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)
1956	3,281	1	0·03	1963	19,882	5	0·03
1957	28,352	5	0·02	1964	14,385	5	0·03
1958	6,183	1	0·02	1965	18,175	3	0·02
1959	24,480	6	0·02	1966	17,567	3	0·02
1960	4,636	—	—	1967	13,528	3	0·02
1961	29,225	8	0·03	1968	15,291	3	0·02
1962	11,485	3	0·03	1969	3,392	—	—

Table 20 Vaccination and Immunisation

The following table gives the number of persons under the age of 16 years who were vaccinated or immunised against diphtheria, whooping cough, tetanus and poliomyelitis during the year ended the 31st December, 1969.

Primary Courses	Year of Birth						
	1969	1968	1967	1966	1962-1965	Others under Age 16	Total
Diphtheria	560	14,599	796	173	2,225	572	18,925
Whooping Cough	560	14,599	751	140	288	141	16,319
Tetanus	560	14,596	796	175	2,246	1,423	19,796
Poliomyelitis	508	14,725	1,059	277	1,386	620	18,575
Reinforcing Doses							
Diphtheria	6	887	2,445	229	20,288	5,341	29,196
Whooping Cough	—	866	2,194	164	1,674	188	5,086
Tetanus	6	888	2,495	298	20,542	6,640	30,869
Poliomyelitis	3	857	2,210	240	20,655	5,294	29,259

Table 21 Vaccination against Smallpox

VACCINATIONS AND RE-VACCINATIONS, 1966—69

Year	Vaccinations							
	0-3 mths	3-6 mths	6-9 mths	9-12 mths	1	2-4	5-14	Total
1966	108	218	276	434	8,217	3,719	1,262	14,234
1967	133	148	229	354	8,941	3,969	768	14,542
1968	39	105	161	198	7,496	3,123	712	11,834
1969	33	72	89	139	10,021	3,556	923	14,833

Year	Re-Vaccinations							
	0-3 mths	3-6 mths	6-9 mths	9-12 mths	1	2-4	5-14	Total
1966	—	—	—	1	16	106	996	1,119
1967	—	—	—	1	16	77	509	603
1968	—	—	—	3	11	82	426	522
1969	—	—	—	—	21	159	661	841

Table 22 Tuberculosis—Mortality

Classification	Age at Death in Years																				Total		Grand Total
	0—		1—		5—		15—		25—		35—		45—		55—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory ...	—	—	—	—	—	—	—	—	—	—	1	2	4	1	7	2	19	3	8	3	39	11	50
Non-respiratory	—	—	—	—	—	—	—	2	—	—	2	3	1	1	2	2	7	2	1	1	13	11	24
Totals ...	—	—	—	—	—	—	—	2	—	—	3	5	5	2	9	4	26	5	9	4	52	22	74

Table 23 Tuberculosis—Notifications

		Age Periods														Total all Ages
		0-	1-	2-	5-	10-	15-	20-	25-	35-	45-	55-	65-	75-		
FORMAL NOTIFICATIONS:																
Respiratory, Males ...	...	1	-	2	7	4	16	10	13	24	22	40	29	10	178
Respiratory, Females ...	...	-	2	2	3	3	10	16	20	15	5	10	1	3	90
Non-respiratory, Males	-	-	2	1	-	1	1	3	6	3	3	-	1	21	
Non-respiratory, Females	-	-	-	1	-	-	1	3	2	-	2	4	2	15	
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SUPPLEMENTAL NOTIFICATIONS:																
Respiratory, Males	-	-	-	-	-	-	-	1	-	1	3	3	6	14	
Respiratory, Females	-	-	-	-	-	-	-	-	-	-	2	-	-	2	
Non-respiratory, Males ...	...	-	-	-	-	-	-	-	-	-	-	1	-	-	1
Non-respiratory, Females		-	-	-	-	-	-	1	-	-	-	-	-	-	1	
															<hr/> 18 <hr/>	

The sources of information of the supplemental notifications were – death returns from Local Registrars (2 respiratory), and posthumous notifications (14 respiratory and 2 non-respiratory).

Table 24 Tuberculosis—Number of Cases on Register

Div. No.	Number of cases on register 1st January, 1969				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1969				Per 1,000 Popu- lation	
	Respiratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respiratory		Non-Res- piratory			Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	119	52	18	22	14	5	2	1	20	9	1	—	113	48	19	23	203	2.5
3	137	48	4	5	23	4	1	—	19	3	2	—	141	49	3	5	198	3.6
4	153	69	4	8	8	5	—	1	19	12	—	1	142	62	4	8	216	3.1
5	233	122	15	21	15	17	3	2	5	3	—	—	243	136	18	23	420	3.3
7	110	44	2	5	12	4	—	—	14	6	—	1	108	42	2	4	156	1.3
9	119	91	24	17	12	6	3	1	6	3	—	—	125	94	27	18	264	2.0
10	76	55	6	14	4	2	—	—	5	6	—	—	75	51	6	14	146	3.0
11	184	122	18	16	4	2	1	—	12	13	—	—	176	111	19	16	322	5.6
12	210	141	38	52	6	6	—	—	9	14	—	1	207	133	38	51	429	5.9
13	67	47	9	20	10	8	—	2	9	1	—	1	68	54	9	21	152	1.6
15	78	54	42	18	9	12	3	1	12	11	2	—	75	55	43	19	192	1.8
18	222	116	16	13	19	11	3	1	42	34	5	3	199	93	14	11	317	2.9
20	112	64	21	26	9	3	1	2	31	13	4	5	90	54	18	23	185	1.9
23	200	127	23	36	10	3	—	—	18	7	—	—	192	123	23	35	373	5.4
Leeds R.H.B.	2,020	1,152	240	273	155	88	17	11	221	135	14	13	1,954	1,105	243	271	3,573	2.9
22	250	120	73	55	6	4	1	—	12	6	2	4	244	118	72	51	485	5.8
25	194	123	10	13	9	3	—	—	12	6	2	—	191	120	8	13	332	4.2
26	334	177	42	57	13	8	3	1	66	38	10	14	281	147	35	44	507	4.6
27	214	155	78	62	17	9	—	4	62	52	9	14	169	112	69	52	402	3.2
29	65	34	19	6	7	6	1	1	15	8	1	2	57	32	19	5	113	2.8
31	177	91	40	39	14	2	2	—	27	20	—	4	164	73	42	35	314	2.9
Sheff. R.H.B.	1,234	700	262	232	66	32	7	6	194	130	24	38	1,106	602	245	200	2,153	3.9
West																		
Riding	3,254	1,852	502	505	221	120	24	17	415	265	38	51	3,060	1,707	488	471	5,726	3.2

Table 25 B.C.G. Vaccination

Details of B.C.G. vaccination given to the various categories under Section 28 of the National Health Service Act are shown below:

(a) CONTACTS.—A total of 1,368 contacts were vaccinated as follows:

	Age (years)			
	0-4	5-15	16+	Total
No. vaccinated ...	910	362	96	1,368

(b) SCHOOL CHILDREN.—A total of 19,979 school children were vaccinated under the County scheme, and the following is a summary of the work carried out.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	31,341
Number found to have been vaccinated previously	818
Number of acceptances	25,185
Percentage of acceptances	82.1

Pre-vaccination tuberculin test:

Number of children tested	23,114
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Result of test:

	Heaf Test	Mantoux Test		
Positive	1,946	105		
Negative	17,813	2,213		
Not ascertained	991	46	Total	23,114
Percentage positive	9.9	4.5		9.3

Vaccination:

Number vaccinated—

Following negative Heaf Test	17,766			
Following negative Mantoux Test	2,213	Total	...	19,979

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months						...	...	...	886
Result of test—									
Positive	...	...	...	...	...	815			
Negative	...	...	...	...	...	21			
Not ascertained		...	...	...	...	50	Total	...	886

(c) STUDENTS ATTENDING UNIVERSITIES, TEACHER-TRAINING COLLEGES, TECHNICAL COLLEGES OR OTHER ESTABLISHMENTS FOR FURTHER EDUCATION.

No students were tuberculin tested during 1969.

Table 26 Tuberculosis—Mass Radiography Surveys

A.—LEEDS UNITS

Survey undertaken in Division No.					Number Examined	Abnormalities Discovered			
						Tuberculosis		* Other	Total
						Active	Inactive		
1	(Skipton)...	...	...	...	5,417	2	2	16	20
3	(Keighley)	...	...	...	2,717	5	4	7	16
4	(Shipley)...	...	...	...	275	—	—	—	—
5	(Horsforth)	...	...	...	4,619	4	6	13	23
7	(Harrogate)	...	...	...	4,138	2	3	9	14
9	(Rothwell/Wetherby)	...	...	...	2,290	2	2	6	10
10	(Goole) ...	...	...	...	1,592	†	†	†	†
11	(Castleford)	...	...	...	2,493	3	2	12	17
12	(Pontefract)	...	...	...	2,914	—	2	7	9
13	(Morley)...	...	...	...	2,835	1	3	11	15
15	(Spenborough)	...	...	...	4,017	6	3	18	27
18	(Calder Valley)	...	...	...	5,017	5	2	11	18
20	(Colne Valley)	...	...	...	5,639	5	5	23	33
23	(Hemsworth)	...	...	...	2,166	1	1	21	23
TOTALS					46,129	36	35	154	225

† Results unobtainable

B.—SHEFFIELD UNITS

Survey undertaken in Division No.					Number Examined	Abnormalities Discovered			
						Tuberculosis		* Other	Total
						Active	Inactive		
22	(Wortley)	...	...	...	1,307	3	2	78	83
25	(Barnsley)	...	...	...	1,755	4	3	49	56
26	(Wath) ...	...	...	...	3,914	7	8	231	246
TOTALS ...					6,976	14	13	358	385

Totals for the County Area ... 53,105 50 48 512 610

*Details of the 512 “ Other ” abnormalities are as follows:—

	<i>Leeds Region</i>	<i>Sheffield Region</i>
1. Abnormalities of the bony thorax and soft tissues— congenital	1	—
2. Abnormalities of the bony thorax and soft tissues— acquired	—	2
3. Tumours of the bony thorax; primary and secondary	1	—
4. Congenital malformations of the lungs	—	—
5. Bacterial and virus infections of the lungs ...	32	26
6. Other infections of the lungs	1	23
7. Bronchiectasis	12	1
8. Honeycomb lung	—	—
9. Emphysema	2	13
10. Pulmonary fibrosis—non-tuberculous	38	17
11. Pneumoconiosis	13	157
12. Spontaneous pneumothorax	2	—
13. Benign tumours of lungs and mediastinum ...	3	1
14. Carcinoma of the lung and mediastinum ...	12	7
15. Metastases in the lung and mediastinum... ..	—	—
16. Enlarged mediastinal and bronchial glands— non-tuberculous	3	1
17. Sarcoidosis and collagenous	4	—
18. Pleural thickening or calcification—non-tuberculous	8	17
19. Abnormalities of diaphragm and œsophagus— congenital and acquired	9	4
20. Congenital abnormalities of heart and vessels ...	3	—
21. Acquired abnormalities of the heart and vessels	8	66
22. Miscellaneous	2	23
23. Pneumoconiosis with tuberculosis	—	—
24. Awaiting classification	—	—
	<hr/> 154 <hr/>	<hr/> 358 <hr/>

Table 27 Venereal and Sexually Transmissible Diseases—New Cases, 1938-69

Year	Syphilis	Gonorrhœa	Other Conditions	Total of New Patients
1938	346	650	503	1,499
1939	403	678	593	1,674
1940	299	499	497	1,295
1941	331	552	587	1,470
1942	423	479	735	1,637
1943	487	654	1,344	2,485
1944	413	560	1,383	2,356
1945	473	767	1,419	2,659
1946	723	1,140	1,859	3,722
1947	573	729	1,511	2,813
1948	463	550	1,403	2,416
1949	435	383	1,360	2,178
1950	357	304	1,447	2,108
1951	247	171	1,212	1,630
1952	219	211	1,275	1,705
1953	214	182	1,228	1,624
1954	178	152	1,189	1,519
1955	175	135	1,168	1,478
1956	155	99	1,143	1,397
1957	152	125	1,078	1,355
1958	124	138	1,129	1,391
1959	112	405	1,352	1,869
1960	83	338	1,550	1,971
1961	85	286	1,669	2,040
1962	69	244	1,623	1,936
1963	74	272	1,734	2,080
1964	67	286	1,841	2,194
1965	57	327	2,153	2,537
1966	48	406	2,160	2,614
1967	47	510	2,255	2,812
1968	47	506	2,527	3,080
1969	30	537	2,845	3,412

Table 8 Syphilis—Type and stage of disease, 1950-69

Year	Syphilis			
	Acquired		Congenital	
	Early	Late	Under 1 year	Over 1 year
1950	76	221	4	56
1951	58	144	4	41
1952	19	163	1	36
1953	9	155	1	49
1954	7	144	—	27
1955	6	128	1	40
1956	9	120	—	26
1957	1	122	—	29
1958	5	99	—	20
1959	12	80	—	20
1960	—	73	—	10
1961	4	67	—	14
1962	4	55	1	9
1963	5	57	—	12
1964	8	51	1	7
1965	8	45	—	4
1966	10	34	—	4
1967	8	33	—	6
1968	7	35	—	5
1969	9	18	—	3

Table 29 Venereal Diseases etc.—Distribution of New Cases by Treatment Centres

Special Treatment Centre	Syphilis	Gonor-rhoea	Other Con-ditions	Total
Barnsley Clinic, Queen's Road	3	15	199	217
Bradford St. Luke's Hospital	—	66	243	309
Burnley Victoria Hospital	1	7	19	27
Dewsbury General Hospital	1	31	163	195
Doncaster Royal Infirmary	5	82	409	496
Halifax Royal Infirmary	2	34	131	167
Harrogate General Hospital	3	29	153	185
Huddersfield Royal Infirmary	2	32	129	163
Hull, Mill Street Clinic	—	10	25	35
Keighley Victoria Hospital	4	43	118	165
Leeds General Infirmary	2	75	471	548
Oldham & District General Hospital	—	—	6	6
Rotherham Moorgate General Hospital	2	30	203	235
Sheffield Royal Hospital	—	5	72	77
Sheffield Royal Infirmary	—	8	37	45
Wakefield Clayton Hospital	4	64	420	488
York County Hospital	1	6	47	54
	30	537	2,845	3,412

Table 30 Venereal Diseases etc.—New Cases—Sex Distribution

	Males	Females	Total
Syphilis	18	12	30
Gonorrhoea	347	190	537
Chancroid	—	—	—
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	618	—	618
Non-gonococcal Urethritis with Arthritis	11	—	11
Trichomoniasis	41	185	226
Late or Latent Treponematoses—non-syphilitic	—	—	—
Other Conditions requiring treatment	459	381	840
Not requiring treatment	661	475	1,136
Undiagnosed at 31st December, 1969	4	10	14
	2,159	1,253	3,412

Table 31 Gonorrhoea—New Cases—Age Distribution

Sex	Under 20		20 to 24		25 and over	
Males	57	16%	120	34%	170	50%
Females	72	38%	65	34%	53	28%

Table 32 Venereal Diseases etc.—Case finding

Total number of contacts reported	...	68				
Located and examined	... ..		48			
Not infected	... ..			9		
Infected	... ..			39		
Already under treatment	...				—	
Brought under treatment	...				39	
Syphilis	... ..					—
Gonorrhœa	... ..					26
Other conditions	... ..					13
Located	... ..		10			
Not examined	... ..			7		
Transferred to other authority	...			3		
Not located	... ..		10			
Insufficient information	... ..			4		
Unable to locate	... ..			6		

Table 33 Antenatal patients with positive serological tests for syphilis

Total number reported	Transferred to other local authorities	West Riding patients with positive tests	Not referred to Special Clinics	Referred to Special Clinics	Found to have Syphilis		Found not to have Syphilis
					New patients	Old patients	
17	6	11	1	10	2	3	6

Table 34 Contacts of antenatal patients found to have syphilis

Number Examined	Found to have Syphilis	Found not to be infected
—	—	—

Table 35 Venereal Diseases etc.—Defaulters

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
113	69	22	18	4	111	95

Table 36 Gonorrhœa—New Cases—Males/Females Numbers and Ratios

Year	Gonorrhœa		Ratio		
	Males	Females	Males		Females
1961	204	82	2·5	:	1
1962	185	59	3·1	:	1
1963	187	85	2·2	:	1
1964	211	75	2·8	:	1
1965	224	103	2·2	:	1
1966	265	141	1·9	:	1
1967	341	169	2·0	:	1
1968	343	163	2·1	:	1
1969	347	190	1·8	:	1

Table 37 Divisional Administration

Div. No.	County Districts	Population (Estimated Mid. 1969)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Bowland R. Sedbergh R. Settle R. Skipton R.	10,040 5,020 5,620 12,940 4,940 3,760 13,770 24,410	2,764 3,519 7,101 4,211 83,325 52,674 152,088 146,077	Dr. M. Hunter Mr. K. A. Knowles Miss F. Stevenson	9, High Street, Skipton Tel. Skipton 2438/9
		80,500	451,759		
3	Keighley B.	55 400	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson (D.N.O. Vacant)	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U. Bingley U. Denholme U. Shipley U.	13,720 25,090 2,660 29,010	2,834 11,418 2,536 2,184	Dr. J. Battersby Mr. F. G. Falking- ham Miss H. J. Watts	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
		70,480	18,972		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	37,600 29,440 18,550 19,820 13,090 7,280	5,321 6,856 2,706 8,610 2,934 39,378	Dr. A. Telford Burn Mr. A. Hartley Miss D. Topley	The Green, Horsforth Tel. Horsforth 5821
		125,780	65,805		
7	Harrogate B. Ripon City Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	62,680 11,840 11,120 17,750 14,850	8,320 1,812 2,494 75,008 124,860	Dr. N. V. Hepple Mr. L. R. Wilkinson Miss M. L. Griffin	Municipal Offices, Harrogate Tel. Harrogate 68954
		118,240	212,494		
9	Garforth U. Rothwell U. Stanley U. Tadcaster R. Wetherby R.	21,620 27 610 19,720 33 570 31,260	4,020 10,704 4,866 72,992 64,415	Dr. W. D. Dolton Mr. F. H. Attack Miss M. P. Bramley	Hallfield Lane, Wetherby Tel. Wetherby 2738 AND Oulton Lane, Rothwell LS26 0ED Tel. Rothwell 2326/7
		133,780	156,997		

Div. No.	County Districts	Population (Estimated Mid. 1969)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
10	Goole B. Selby U. Goole R. Selby R.	18,430	1,274	Dr. S. K. Appleton Mr. R. Towell Miss D. M. E. Gold- thorpe	6/7, Belgravia, Goole Tel. Goole 4216 and 2923
		11,340	3,847		
		9,080	36,782		
		9,700	32,910		
		48,550	74,813		
11	Castleford B. Normanton U.	39,160	4,400	Dr. J. M. Paterson Mr. C. R. Pickering Mrs. M. Craig	"Castledene," Pontefract Road, Castleford Tel. Castle- ford 4201
		18,440	3,067		
		57,600	7,467		
12	Pontefract B. Featherstone U. Knottingley U. Osgoldcross R.	30,820	4,865	Dr. J. F. Fraser Mr. W. Carver Mrs. M. Craig	Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
		15,330	4,424		
		17,010	2,833		
		9,330	33,950		
		72,490	46,072		
13	Morley B. Ossett B. Horbury U. Wakefield R.	44,120	9,494	Dr. G. Ireland Mr. A. Wright Miss A. Hibbard	Windsor House, Morley Tel. Morley 4281/2
		17,070	3,331		
		9,070	1,280		
		23,670	21,347		
		93,930	35,452		
15	Batley B. Spenborough B. Heckmondwike U. Mirfield U.	41,810	4,457	Dr. W. M. Douglas Mr. P. Marshall Miss I. Endean	Health Centre, Greenside, Cleckheaton Tel. Cleck- heaton 3501/4 AND Market Place, Batley Tel. Batley 3141
		38,990	8,249		
		9,050	696		
		16,070	3,394		
		105,920	16,796		
18	Brighouse B. Todmorden B. Elland U. Hebden Royd U. Queensbury and Shelf U. Ripponden U. Sowerby Bridge U. Hepton R.	33,130	7,873	Dr. N. E. Gordon Mr. H. Marshall Miss C. J. Barker	Lawson Road Brighouse Tel. Brighouse 2515 AND Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 2495
		15,430	12,789		
		18,300	5,949		
		8,800	7,083		
		10,350	2,795		
		4,970	13,289		
		16,610	5,763		
		3,530	21,757		
		111,120	77,298		

Div. No.	County Districts	Population (Estimated Mid. 1969)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
20	Colne Valley U.	21,000	16,054	Dr. P. M. Sammon Mr. G. A. Beatson Miss J. L. Law	6/8, St. Peter's Street, Huddersfield HD1 1DN Tel. Huddersfield 29526/8
	Denby Dale U.	10,630	10,166		
	Holmfirth U.	18,960	17,648		
	Kirkburton U.	19,710	13,851	Dr. F. C. Armstrong Mr. P. Fullwood Mrs. M. Orr	Mortomley Hall, High Green, nr. Sheffield S30 4HR Tel. High Green 292
	Meltham U.	6,370	5,906		
	Saddleworth U.	19,620	18,485		
22		96,290	82,110	Dr. J. S. Walters Mr. G. Ellis Miss D. Marsh	Adiscombe House, Barnsley Road, Hemsworth Tel. Hemsworth 377/8
	Hoyland Nether U.	16,100	2,000		
	Penistone U.	7,630	5,588		
	Stocksbridge U.	13,290	4,630	Dr. C. G. Oddy Mr. L. S. Wrigg Miss M. E. Pilling	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
	Penistone R.	7,500	29,007		
	Wortley R.	39,230	48,130		
23		83,750	89,355	Dr. D. J. Cusiter Mr. P. Goddard Miss V. Dunford	Dunford House, Wath upon Dearne Tel. Wath 2251/2
	Hemsworth U.	15,050	4,164		
	Hemsworth R.	53,410	29,021		
25		68,460	33,185	Dr. R. Stalker Mr. C. W. Vallance Miss M. E. Young	Station Road, Doncaster Tel. Doncaster 61571
	Cudworth U.	9,170	1,746		
	Darfield U.	7,250	2,018		
	Darton U.	15,220	4,716		
	Dodworth U.	4,400	1,859		
	Royston U.	8,570	1,426		
26	Wombwell U.	18,970	3,840		
	Worsbrough U.	16,310	3,420		
		79,890	19,025		
27		110,080	13,925		
	Conisbrough U.	17,740	1,589		
	Dearne U.	26,550	3,888		
	Mexborough U.	16,340	1,452		
	Rawmarsh U.	19,740	2,600		
	Swinton U.	14,360	1,717		
27	Wath upon Dearne U.	15,350	2,679		
		126,320	89,243		
	Adwick le Street U.	18,720	3,605		
	Bentley with Arksey U.	23,810	4,951		
	Tickhill U.	3,030	5,578		
	Doncaster R.	80,760	75,109		

Div. No.	County Districts	Population (Estimated Mid. 1969)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
29	Thorne R.	40,060	38,408	Dr. G. Higgins Mr. J. T. Howitt Miss D. M. E. Goldthorpe	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	14,990 25,960 66,690	4,785 20,070 28,856	Dr. J. T. Clow Mr. A. Hill Mrs. A. Brooks	"Edenthorpe," Grove Road, Rotherham Tel. Rotherham 3131/2
		107,640	53,711		

Table 38 Dental Services for Expectant and Nursing Mothers and children under 5 years

Attendances and Treatment

	Children 0—4 (incl.)	Expectant and Nursing Mothers
First Visit	1,037	331
Subsequent Visits	685	1,071
Additional Courses of Treatment commenced ...	56	12
Number of Fillings	1,019	752
Teeth Filled	929	702
Teeth Extracted	1,810	800
General Anæsthetics	734	131
Emergencies	310	48
Patients X-Rayed	10	17
Prophylaxis	85	168
Teeth otherwise conserved... ..	45	—
Teeth Root Filled	—	5
Inlays	—	4
Crowns	—	13
Courses of Treatment Completed... ..	892	307

Prosthetics

Patients supplied with F.U. or F.L. (First Time)	61
Patients supplied with Other Dentures	75
Number of Dentures supplied	229

Anæsthetics

General Anæsthetics administered by Dental Officers	865
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Inspections

	Children 0—4 (incl.)	Expectant and Nursing Mothers
Number of First Inspections	A. 1,471	D. 351
Number in A. and D. requiring treatment	B. 1,131	E. 336
Number in B. and E. offered treatment	C. 1,087	F. 336

Sessions

Number of sessions devoted to M. & C.W. patients

For Treatment	457
For Health Education	—

Table 39 Antenatal Relaxation Classes

No. of sessions:							
(a)	separate	...	...	...	...	...	4,252
(b)	combined with antenatal clinics	...	...	...	...	...	82
TOTAL							4,334
No. of women attending:							
(a)	hospital booked	...	...	...	...	...	5,090
(b)	domiciliary booked	...	...	...	...	...	851
TOTAL							5,941
Total number of attendances:							
(a)	hospital booked	...	...	...	...	...	24,177
(b)	domiciliary booked	...	...	...	...	...	3,878
TOTAL							28,055

Table 40 Phenylketonuria—Details of Tests undertaken by Phenistix method, March, 1960—December, 1969

Total number tested	...	...	...	...	...	...	283,857
Number of confirmed cases	...	...	...	...	...	...	17
Ratio of true cases of phenylketonuria to children tested	...						1 : 16,697

Table 41 Ortolani Testing for Congenital Dislocation of the Hip—Summary of tests carried out, 1964-69

	1964	1965	1966	1967	1968	1969
(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted	29	17	52	69	64	62
No. included in (a) referred by staff employed by the Authority	14	9	27	31	27	21
(b) Cases referred to specialist and said not to be congenital dislocation of the hip ...	29	31	62	43	78	61
(c) Cases referred to specialist, not splinted but given further review appointments	15	13	24	18	35	45

Table 42 Illegitimate Children—Analysis of Cases

						West Riding Cases	Non- County Cases	Total
Number of cases dealt with during the year:								
Referred by Moral Welfare Organisations						171	24	195
Ascertained by staff of the Health Department... ..						908	3	911
Referred by other services... ..						279	3	282
Totals ...						1,358	30	1,388
Analysis of cases:								
Married	{	with previous illegitimate children ...				99	1	100
		without previous illegitimate children ...				159	2	161
Unmarried	{	with previous illegitimate children ...				188	3	191
		without previous illegitimate children ...				853	24	877
Widowed or Divorced	{	with previous illegitimate children ...				30	—	30
		without previous illegitimate children ...				29	—	29
Totals ...						1,358	30	1,388
Ages:								
Under 15 years of age						7	1	8
15—19 years of age						542	19	561
20—24 years of age						446	7	453
25—29 years of age						186	2	188
30—39 years of age						157	1	158
40 years of age and over						20	—	20
Totals ...						1,358	30	1,388
Disposal:								
Cases settled —Marriage						86	1	87
Baby died... ..						28	1	29
Grandparents taking baby						38	1	39
Baby adopted						190	16	206
Baby fostered						39	—	39
Mother keeping baby						962	10	972
Cases referred elsewhere						5	—	5
Cases not finally settled						10	1	11
Totals ...						1,358	30	1,388

Table 43 Illegitimate Children—Accommodation in Moral Welfare Homes

Name of Home	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Borrowash, Derby—St. Joseph's ...	1	—	—	Roman Catholic Church
Bradford—Holybrook House ...	11	5	—	Church of England
Bradford—Oakwell House ...	7	2	2	Bradford Corporation
Halifax—St. Margaret's House ...	19	3	—	Church of England
Huddersfield—Bryanwood ...	10	1	—	Methodist Church
Huddersfield—St. Katherine's Hostel ...	7	—	—	Church of England
Kendal—St. Monica's ...	1	—	—	Church of England
Leeds—Browning House ...	18	—	—	Voluntary Committee
Leeds—Mount Cross, Bramley ...	5	—	—	Salvation Army
Leeds—St. Margaret's Home ...	14	1	—	Roman Catholic Church
Lincoln—The Quarry Maternity Home	1	—	—	Church of England
London—"Crossways", Clapton ...	1	—	—	Salvation Army
Manchester—Lorna Lodge, Didsbury ...	1	1	—	Methodist Church
Northampton—Elmleigh Mother & Baby Home ...	1	—	—	National Adoption Soc.
Pontefract—The Haven ...	16	3	3	Church of England
Salford—St. Teresa's Home ...	1	—	—	Roman Catholic Church
Sheffield—St. Agatha's Hostel ...	13	4	—	Church of England
Sutton on Hull—Sutton House ...	2	—	—	Church of England
Windsor—St. Michael's Hostel ...	1	—	—	Church of England
York—Heworth Moor House ...	5	2	—	Church of England
	135	22	5	

Table 44 Premature Babies

Total adjusted live births—30,274 Number of live premature births—2,060 Percentage of premature live births to total live births—6.8

Number born dead—246

Weight Group	Number of Premature Births					Number Dying														Number Surviving over 28 days					Percentage Survival 1969	Percentage Survival in previous years																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
	Born Alive					Born Dead	First Week								Second Week						A	B1	B2	C		Total																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
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- A — Born in Domiciliary Practice.
B1—Born in Private Nursing Home.
B2—Born in Maternity Home.
C — Born in General Hospital.

The weight groups in the first column of this table should be read as under :—
“ 5—5½ lb.” means “ Over 5 lb. up to and including 5½ lb.”
“ 4½—5 lb.” means “ Over 4½ lb. up to and including 5 lb.”
The remaining weight groups should be read in the same way.

Table 45 Distribution of Welfare Foods

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin A. & D. Tablets (Packets)	Orange Juice (Bottles)
1965	111,956	33,080	29,129	376,350
1966	94,779	30,993	27,073	417,351
1967	81,351	28,835	24,038	442,498
1968	72,262	28,314	22,018	405,803
1969	52,771	26,595	22,727	447,379

Table 46 Day Nurseries

Division Number	Day Nursery	Number of Places Provided	Average Daily Attendance
3	Keighley	50	34
4	Shipley	50	42
7	Harrogate	40	30
15	Heckmondwike	40	30
18	Brighouse	40	23

Table 47 Midwifery—Hospital and Domiciliary Confinements

Divi- sion No.	Area	Population (estimated mid-1969)	Total noti- fied births (Live and Still)	Place of Birth					
				Hospital				Domici- liary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and inclu- ding 5th day	After 5th but before 10th day		
1	Skipton	80,500	1,149	1,081	13	110	502	68	6
3	Keighley	55,400	883	853	21	283	442	30	3
4	Shipley	70,480	1,132	1,027	94	89	514	105	9
5	Horsforth	125,780	1,937	1,829	203	202	913	108	6
7	Harrogate	118,240	1,658	1,580	238	310	376	78	5
9	Rothwell/Wetherby	133,780	2,510	1,918	521	457	332	592	24
10	Goole	48,550	836	622	54	56	78	214	26
11	Castleford	57,600	947	784	116	236	144	163	17
12	Pontefract	72,490	1,314	1,016	117	180	357	298	23
13	Morley	93,930	1,679	1,333	329	159	198	346	21
15	Spenborough	105,920	2,122	1,993	269	214	295	129	6
18	Calder Valley	111,120	1,858	1,426	82	84	116	432	23
20	Colne Valley	96,920	1,535	1,333	47	144	331	202	13
22	Wortley	83,750	1,459	1,235	110	107	641	224	15
23	Hemsworth	68,460	1,282	972	27	108	446	310	24
25	Barnsley	79,890	1,329	990	29	59	420	339	26
26	Wath	110,080	1,942	1,585	46	456	287	357	18
27	Doncaster	126,320	2,105	1,824	157	491	157	281	13
29	Thorne	40,060	831	661	47	212	55	170	20
31	Rotherham	107,640	2,124	1,705	475	502	303	419	20
Leeds Hospital Board Region		1,238,540	20,842	17,767	2,131	2,632	5,044	3,075	15
Sheffield Hospital Board Region		547,740	9,790	8,000	864	1,827	1,863	1,790	18
West Riding Administrative County		1,786,280	30,632	25,767	2,995	4,459	6,907	4,865	16

Table 48 Midwifery—Analgesia

Div. No.	Area						Percentage receiving Analgesia			
							Pethi- dine alone	Tri- lene alone	Tri- lene with Pethi- dine	Total
1	Skipton	...	...	...	...	...	11	37	46	94
3	Keighley	...	...	...	...	...	4	10	86	100
4	Shipley	...	...	...	...	...	9	6	76	91
5	Horsforth	...	...	...	...	...	17	41	27	85
7	Harrogate	...	...	...	...	...	17	26	37	80
9	Rothwell/Wetherby	...	...	...	...	...	18	27	35	80
10	Goole	...	...	...	...	...	8	37	37	82
11	Castleford	...	...	...	...	...	9	43	33	85
12	Pontefract	...	...	...	...	...	27	12	36	75
13	Morley	...	...	...	...	...	13	30	44	87
15	Spenborough	...	...	...	...	...	5	25	63	93
18	Calder Valley	...	...	...	...	...	13	23	48	84
20	Colne Valley	...	...	...	...	...	9	24	48	81
22	Wortley	...	...	...	...	...	40	26	12	78
23	Hemsworth	...	...	...	...	...	17	34	33	84
25	Barnsley	...	...	...	...	...	17	30	30	77
26	Wath	...	...	...	...	...	19	24	33	76
27	Doncaster	...	...	...	...	...	10	25	50	85
29	Thorne	...	...	...	...	...	32	11	43	86
31	Rotherham	...	...	...	...	...	25	21	30	76
Leeds Hospital Board Region		...	...	...	...	...	14	28	42	84
Sheffield Hospital Board Region		...	...	...	...	...	22	24	33	79
West Riding Administrative County		...	...	...	...	...	17	26	39	82

Table 49 Health Visiting

Excluding their work in schools and general practitioners' surgeries, health visitors dealt with a total of 190,972 cases. Details are given below of the various case categories; where appropriate, cases have been included under more than one heading.					
					<i>Cases</i>
Expectant mothers	...	...	...	...	2,818
Children born in 1969	...	...	...	...	30,045
Children born in 1968	...	...	...	...	30,058
Children born in 1964-67	...	...	...	...	58,555
Persons aged 65 and over (excluding 'domestic help only' visits)	...	...	...	...	18,968
					(includes 8,012 visited at the special request of a general practitioner or hospital)
Mentally disordered persons	...	...	...	...	661
					(includes 317 visited at the special request of a general practitioner or hospital)
Persons, excluding maternity cases, discharged from hospital (other than mental hospitals)					2,680
					(includes 1,943 visited at the special request of a general practitioner or hospital)
Other cases (including 'domestic help only' visits)	...	...	...	...	45,575
Visits to tuberculous households	...	...	...	...	1,870
Visits to households on account of other infectious diseases	...	...	...	...	2,039
Health visitors attended 40,883 clinic sessions. Details are given below of the various clinics.					
<i>Type of Clinic</i>					<i>No. of Sessions</i>
Child health (infant welfare)	...	...	...	...	26,862
Screening for infant deafness	...	...	...	...	5,516
Cervical cytology	...	...	...	...	1,771
Vaccination and immunisation	...	...	...	...	2,000
Ultra violet light	...	...	...	...	55
Minor ailments	...	...	...	...	1,137
Cardiac	...	...	...	...	14
Pædiatric	...	...	...	...	421
Family planning	...	...	...	...	7
Ophthalmic	...	...	...	...	1,634
Orthopædic	...	...	...	...	85
Ear, nose and throat	...	...	...	...	93
Dermatological	...	...	...	...	5
Diabetic	...	...	...	...	188
Chest	...	...	...	...	730
Geriatric	...	...	...	...	195
Others	...	...	...	...	170
Health Education—					
Mothercraft and relaxation groups	...	...	...	...	1,695
Mothers' Clubs	...	...	...	...	260
Schools	...	...	...	...	1,549
Parent/Teacher groups	...	...	...	...	12
Other groups and organisations	...	...	...	...	287
					3,803
A total of 35,494 hours was spent in schools and 10,049 home visits were made in connection with school health activities.					

Table 50 Home Nursing—Total Cases Visited

Types of cases attended								No. of cases attended	No. of visits by Home Nurses
Medical	...	...	...	...	...	...	...	27,096	642,481
Surgical	...	...	...	...	...	...	...	9,135	173,650
Infectious diseases...	...	...	...	...	...	...	...	407	2,742
Tuberculosis	...	...	...	...	...	...	...	270	11,818
Maternal Complications	...	...	...	...	...	...	...	891	8,745
Others	...	...	...	...	...	...	...	403	9,648
Totals								38,202	849,084
Age groups									
0—4...	...	...	...	...	...	...	...	1,654	9,767
5—64	...	...	...	...	...	...	...	15,706	288,239
65 years and over	...	...	...	...	...	...	...	20,842	551,078
Totals								38,202	849,084
Patients included in the above who have had more than 24 visits during the year								8,849	574,428

Table 51 Home Nursing—Completed Cases

Classification of Cases by Disease:										No. of Cases
Disease										
Tuberculosis	...	...	...	...	...	...	...	...	...	216
Other infectious diseases	...	...	...	...	...	...	...	...	...	412
Parasitic diseases	...	...	...	...	...	...	...	...	...	240
Malignant and lymphatic neoplasms	...	...	...	...	...	...	...	...	...	1,968
Asthma	...	...	...	...	...	...	...	...	...	118
Diabetes mellitus	...	...	...	...	...	...	...	...	...	538
Anæmias	...	...	...	...	...	...	...	...	...	2,157
Vascular lesions affecting central nervous system	...	...	...	...	...	...	...	...	...	1,653
Other mental and nervous diseases	...	...	...	...	...	...	...	...	...	672
Diseases of the eye...	...	...	...	...	...	...	...	...	...	106
Diseases of the ear	...	...	...	...	...	...	...	...	...	387
Diseases of heart and arteries	...	...	...	...	...	...	...	...	...	1,824
Diseases of veins	...	...	...	...	...	...	...	...	...	908
Upper respiratory diseases	...	...	...	...	...	...	...	...	...	812
Other respiratory diseases...	...	...	...	...	...	...	...	...	...	2,622
Constipation	...	...	...	...	...	...	...	...	...	1,129
Other diseases of digestive system	...	...	...	...	...	...	...	...	...	2,443
Diseases of urinary system and male genital organs	...	...	...	...	...	...	...	...	...	945
Diseases of breast and female genital organs	...	...	...	...	...	...	...	...	...	742
Complications of pregnancy and puerperium	...	...	...	...	...	...	...	...	...	851
Diseases of skin and subcutaneous tissues	...	...	...	...	...	...	...	...	...	1,554
Diseases of bones, joints and muscles	...	...	...	...	...	...	...	...	...	991
Injuries	...	...	...	...	...	...	...	...	...	2,140
Senility	...	...	...	...	...	...	...	...	...	1,159
Other defined and ill-defined diseases or disabilities	...	...	...	...	...	...	...	...	...	1,379
Diseases not specified	...	...	...	...	...	...	...	...	...	742
Total										28,708
Nursing Treatment:										
Type										
Injections	...	...	...	...	...	...	...	...	...	6,780
General Nursing	...	...	...	...	...	...	...	...	...	7,466
Enemas	...	...	...	...	...	...	...	...	...	1,256
Dressings	...	...	...	...	...	...	...	...	...	7,874
Bed baths	...	...	...	...	...	...	...	...	...	1,059
Wash-outs, douches, etc.	...	...	...	...	...	...	...	...	...	194
Changing of pessaries	...	...	...	...	...	...	...	...	...	106
Preparation for diagnostic investigation...	...	...	...	...	...	...	...	...	...	562
Others	...	...	...	...	...	...	...	...	...	3,411
Total										28,708

The total number of cases receiving injections was 7,265 but, in a small proportion of cases, the injections were given during the course of a general nursing visit.

Injections:	Type										No. of Cases
Insulin	322
Drugs for anæmia, debility, etc.	2,772
Antibiotics	2,446
Drugs for cardio-renal diseases	424
Others	1,301
Total										...	7,265
Referral of Cases:	Source										
General practitioners	23,471
Hospitals	3,840
Health department staff	894
Others	503
Total										...	28,708
Disposal of Cases:											
Convalescent	15,012
Transferred to hospital	4,347
Died	3,691
Others	5,658
Total										...	28,708

Table 52 Ambulance Services - Accidents Attended

Type and number of Accidents attended		Patients dealt with	Fatal
Directly provided Service 23 Ambulance Stations			
Road	4,424	6,316	118
Street	1,597	1,647	3
Works	1,370	1,389	8
Home	5,185	5,216	12
School	498	519	1
Sport	468	479	1
Others	43	46	1
Total	13,585	15,612	144
Agency Services (7)			
Road	183	260	3
Street	35	35	—
Works	80	81	1
Home	111	111	—
School	8	8	—
Sport	39	39	—
Others	4	4	—
Total	460	538	4

Table 53 Health Education - Summary of Activities

Subject	Estimated Audience			
	Clinics	Schools	*Other	Total
Antenatal, Childbirth	10,449	1,898	402	12,749
Moterhcraft and Child Development ...	6,839	5,052	527	12,418
Personal Hygiene	1,965	17,485	832	20,282
Personal Relationships, V.D.	442	8,788	6,075	15,305
Accident Prevention	3,427	6,533	1,599	11,599
Vaccination and Immunisation	256	325	—	581
Nutrition and General Health	905	3,224	582	4,711
Cancer Education	237	2,984	1,326	4,547
Family Planning	10	—	215	225
Local Health Services	143	2,220	2,084	4,447
Care of the Aged	—	83	—	83
First Aid	—	1,030	307	1,337
Totals ...	24,673	49,622	13,949	88,244

*Includes Mothers' Clubs, Women's Institutes, Guides, Scouts, Youth Clubs, St. John Cadets Darby and Joan Clubs, etc.

Table 54 Provision of Nursing Equipment in the Home

Item	Number on loan	Number avail- able for issue	Total	Number of issues during year
Bath lift	—	1	1	—
Bath seat	35	1	36	46
Bedding: blankets, pillows and cases, sheets, etc.—pieces	684	369	1,053	1,449
Bed blocks	44	76	120	65
Bed cradles	524	92	616	986
Bed pans	1,495	457	1,952	3,401
Bed rests	753	154	907	1,643
Bed tables	9	12	21	14
Bedsteads: hospital, with self-lifting pole, and other	307	16	323	479
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying) etc.	35	7	42	43
Commodes: chair and other	1,060	19	1,079	2,153
Cushions: air and 'Dunlopillo'	313	76	389	433
Enuresis alarms	374	35	409	1,667
Fracture boards	103	5	108	137
Hot water bottles	2	13	15	2
Hydraulic hoists	40	4	44	66
Lifting pole and chain	40	7	47	65
Mattresses: various types	397	31	428	613
Pressure rings... ..	684	164	848	1,254
Rubber/plastic sheets	1,329	222	1,551	2,157
Sputum mugs	613	112	725	622
Tables: 'Amesbury' play	1	—	1	1
Walking aids: 'Amesbury', 'Bonaped', 'Zimmer', tripod, 'Companion', 'Fordham', 'Mycroft', 'Welwyn', 'Winchester', etc. crutches and walk- ing sticks	1,705	162	1,867	2,573
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	729	52	781	1,543
Miscellaneous	85	35	120	148
	11,361	2,122	13,483	21,560

Table 55 Chiropody Treatment

	Voluntary Association Schemes	Direct Service by County Council	Total
<i>Number of sessions held:</i>			
In voluntary association premises	3,053	—	3,053
In clinic premises	—	11,410	11,410
	3,053	11,410	14,463
<i>Number of patients treated:</i>			
In chiropodists' surgeries:			
Pensioners	4,718	6,304	11,022
Physically handicapped	57	153	210
Expectant mothers	7	4	11
In voluntary association or clinic premises:			
Pensioners	6,041	20,266	26,307
Physically handicapped	131	356	487
Expectant mothers	2	17	19
Domiciliary treatment:			
Pensioners	2,439	12,077	14,516
Physically handicapped	120	460	580
Expectant mothers	—	—	—
Total number of patients treated	13,515	39,637	53,152
<i>Total number of treatments given:</i>			
Pensioners	59,377	184,391	243,768
Physically handicapped	1,109	3,806	4,915
Expectant mothers	17	51	68
	60,503	188,248	248,751
Number of patients treated per session	8·7	8·4	8·5
Percentage of total patients treated receiving domiciliary treatment	18·9	31·6	28·4
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	5·2	15·1	20·3

Table 56 Domestic Help

Classification of Cases Assisted	No. of Cases	Hours employed
Over 65 years of age	17,797	2,386,646
Under 65 years of age:		
Chronic sick and tuberculous	1,590	190,863
Mentally disordered	39	3,965
Maternity	485	20,066
Other	627	50,429
	20,538	2,651,969

Table 57 Mental Health Training Centres

The following is a list of the training centres in operation at the end of 1969, with details of the places provided:

Centre	Junior	Adult Male	Adult Female	Special Care	Total
Adwick le Street	38	25	25	—	88
Airedale (Castleford)	40	30	30	4	104
Brighouse Junior	27	—	—	—	27
Ecclesfield	42	26	21	6	95
Harrogate	30	25	25	6	86
Heckmondwike	36	20	12	—	68
Hemsworth... ..	40	20	20	12	92
Horsforth Comprehensive	30	25	25	12	92
Horsforth Junior	27	—	—	—	27
Keighley	50	25	25	—	100
Kirkburton... ..	30	25	25	6	86
Maltby	48	30	30	18	126
Ossett Junior	27	—	—	—	27
Rawcliffe	30	15	15	4	64
Rothwell	30	16	14	4	64
Skipton	24	18	18	4	64
Wath upon Dearne	46	25	25	12	108
West Ardsley	24	23	23	6	76
Wombwell	36	25	40	12	113
Totals	655	373	373	106	1,507

Table 58 Day Centres and Psychiatric Social Clubs

DAY CENTRES:

Club	No. of members	Premises	Meetings	Opened
Harrogate Therapeutic	52	13, Dragon Parade, Harrogate	Daily	October, 1963 (transferred to new premises May, 1967)
Snaith Day Centre	23	Pontefract Road, Snaith	Daily	December, 1963

PSYCHIATRIC SOCIAL CLUBS:

Club	No. of places	Premises	Meetings	Opened
'Beacon Club' Brighouse	20	Divisional Health Office, Police St., Brighouse	Monday evening	January, 1968
Castleford Club	30	Child Welfare Clinic, West Villa, High-town, Castleford	Monday evening	September, 1961
The Contact Club	35	Health Centre, Greenside, Cleckheaton	Tuesday evening	October, 1963
The Glen Social Club	30	Somerset House Clinic, Shipley	Tuesday evening	September, 1961
The Handshake Club	40	Multiple Clinic, Leeds Road, Tadcaster	Tuesday evening	January, 1964
Harrogate Social Club	50	Training Centre, High Street, Starbeck, Harrogate	Tuesday evening	April, 1963
Ilkley Club	30	South Hawksworth Street, Ilkley	Monday evening	February, 1964 Temporarily closed
Morley Social Club	20	Central Clinic, Morley	Thursday evening	January, 1962
Rock Club, Wath upon Dearne	40	Child Welfare Clinic, Church Street, Wath upon Dearne	Fortnightly Thursday evening	August, 1961
Rothwell Club	30	Central Clinic Oulton Lane, Rothwell	Monday evening	August, 1965
Springhead Club	25	Springhead Clinic, Cooper Street, Saddleworth	Thursday afternoon	December, 1964

Table 59 Mental Health—Hospital Admissions

PSYCHIATRIC PATIENTS (admitted by Mental Welfare Officers)

						1968	1969
Informal admissions	...	...	...	...	...	1,812	1,787
Court orders	...	...	...	...	...	5	1
Section 25	...	...	...	...	...	250	207
„ 26	...	...	...	...	...	58	48
„ 29	...	...	...	...	...	523	555
						2,648	2,598

SUBNORMAL PATIENTS

Patients	provided with short-stay care	...	...	268
„	admitted for permanent care	...	...	45
„	under guardianship...	...	...	3
„	awaiting permanent care—urgent	...	...	16
„	awaiting permanent care—non-urgent	...	...	40

Table 60 Mental Health—Number of persons referred to Local Health Authority during year ended 31st December, 1969

Referred by	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Total		
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over				
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.			
General practitioners	8	3	647	1010	—	—	3	—	—	—	6	2	15	8	1	2	—	1	1706
Hospitals, on discharge from in-patient treatment	2	2	542	788	2	—	1	—	—	—	5	1	10	10	3	2	—	1	1370
Hospitals, after or during out-patient or day treatment...	2	1	202	266	—	—	—	1	—	3	1	2	4	—	2	—	—	1	486
Local education authorities	2	—	5	3	—	—	—	—	—	30	29	37	28	20	11	—	—	—	165
Police and courts	—	—	82	51	—	—	1	4	—	—	—	—	12	—	—	—	—	—	150
Other sources	1	3	426	684	1	—	5	1	—	31	19	45	36	21	10	—	—	5	1299
Total	15	9	1904	2802	3	—	10	6	—	75	52	121	86	47	25	13	8	—	5176

Table 61 Mental Health—Number of persons under Local Health Authority
Care at 31st December, 1969

Number of Persons under L.H.A. care at 31.12.69	Mentally Ill				Elderly mentally infirm		Psychopathic				Subnormal				Severely Subnormal				Total
	Under age 16		16 and over		M.	F.	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.			M.	F.	M.	F.	M.	F.	M.	F.	M.	F.			
Total number	4	6	1239	1821	100	221	—	—	10	5	280	213	964	875	266	209	303	310	6826
Attending day training centre	1	—	15	6	3	3	—	—	—	—	213	158	262	250	206	169	167	171	1624
Awaiting entry to training centre	—	—	9	—	—	—	—	—	—	—	16	13	9	11	25	10	1	—	94
Receiving home training	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	8	10
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident in L.A. home/hostel	—	—	18	25	—	—	—	—	—	—	7	—	23	24	6	5	1	2	111
Awaiting residence in L.A. home/hostel	—	—	2	2	—	—	—	—	—	—	1	—	3	—	—	1	22	21	52
Resident at L.A. expense in other homes/hostels	—	—	1	—	—	—	—	—	—	—	—	2	1	2	2	8	9	3	28
Resident at L.A. expense by boarding out in private household	—	—	—	—	—	—	—	—	—	—	1	—	—	1	—	—	1	2	5
Attending day hospitals	—	1	86	86	6	5	—	—	—	—	—	—	1	—	7	5	6	3	206
Receiving home visits and not included above:	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Suitable to attend a training centre	—	—	55	122	7	11	—	—	—	—	10	11	59	73	6	6	39	43	442
Others	3	5	1053	1578	84	202	—	5	—	10	39	29	619	522	20	11	70	70	4320

Table 62 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Dealers Licensed

Number of Licence Holders	Dealing in pre-packed milk			
	Untreated	Pasteurised	Sterilised	Ultra Heat Treated
3,291	603	1,427	2,539	46

Table 63 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers in the County Area

Untreated			Pasteurised					Sterilised		Ultra Heat Treated	
Methylene Blue Test			Phosphatase Test		Methylene Blue Test			Turbidity Test		Colony Count	
Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory
2,264	224	292	1,892	4	1,736	30	130	54	—	16	—

Table 64 Milk (Special Designation) Regulations, 1963—Licensed Establishments for Pasteurising and Sterilising Milk

PASTEURISED MILK:

- Chappell, R. M., Nether End Farm, Denby Dale.
- Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley.
- Dibb, K., Home Farm, Menston.
- Doncaster Co-operative Society Ltd., Dairy Department, York Road, Doncaster.
- Doxey, C., The Dairy, Nutwell Lane, Armthorpe.
- Co-operative Retail Services Ltd., Goole Branch, Centenary Road, Goole.
- Co-operative Retail Services Ltd., Goldcross Branch, Horsefair Dairy, Pontefract.
- Mawer, L. C. & W. O., Glentworth House, Skellow.
- Old Corn Mill Farm (Eldwick) Ltd., Harden Grange, Harden, Bingley.
- Platts, N. H. & Sons, Home Farm, Bretton.
- Salmon, P., Ashbrooke, Littlethorpe, Ripon.
- Whittaker's Dairies Ltd., 77, Tenter Balk Lane, Adwick le Street.
- Rotherham Dairies Ltd., Bramley.

Table 65 Milk (Special Designation) Regulations, 1963—Details of Samples obtained from Licensed Processing Plants

Pasteurised				
Phosphatase Test		Methylene Blue Test		
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Void
656	4	566	2	92

Table 66 Details of Samples obtained from Private Supplies of Water to County Premises

Premises	Source of Supply	Bacteriological Examination		
		Number of samples obtained	Sat.	Unsat.
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main—candle filter	12	12	—
Askham Bryan Agricultural College, Askham Bryan, near York	Bore—untreated	48	48	—
Clint Burnt Yates Endowed School, Burnt Yates, near Harrogate	Bore—untreated	13	13	—
Grantley Hall Adult College, near Ripon	Land Springs—filtered and chlorinated	20	19	1
Ingleborough Hall Special School, Clapham, Settle	Lake water—filtered and chlorinated	19	14	5

Table 67 Details of Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-61

County District or Other Body	Description of Scheme	Date of Application	Estimated Cost of Scheme £
Bowland R.D.	Rimington Sewerage and Sewage Disposal Sawley Sewerage and Sewage Disposal	7th October 7th October	45,150 34,500
Calderdale Water Board	Dog Lane, Stainland Water Supply, Morley Hall, Luddendenfoot Water Supply	12th March 9th July	2,075 6,739
Claro Water Board	Warsill Water Supply	14th August	4,900
Craven Water Board	Clapham, Austwick Water Supply Lawkland Newby and Cold Cotes Water Supply	11th August 11th August	86,500 26,000
Doncaster R.D.	Old Denaby Sewerage	26th March	28,927
Wortley R.D.	Brightholmlea, Bradfield Water Supply	11th September	5,160

Table 68 School Swimming Pools

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Aireborough Grammar	30,000	Conventional	Sand	Chlorine Gas	—
Armthorpe Junior	12,400	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	—
Aston Lodge C.P.	—	—	—	—	Pool in planning stage
Bardsey Primary	870	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Bewerley Park Centre for outdoor pursuits	12,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Bingley Grammar	46,400	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	—
Boroughbridge County Primary	6,000	Learner	Diatoma- ceous Earth	Drip Feed	—
Bridge House Special School, Harewood	4,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Brighouse Woodhouse Junior	8,800	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969
Collingham C.E.	10,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Copmanthorpe J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool under construction
Darton Barugh J.M.I.	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Darton Kexbrough	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Ermysted's Grammar Skipton	29,000	Conventional	Sand	Chlorine Gas	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Featherstone R.C.	46,000	Conventional	Sand	Chlorine Gas	—
Felkirk Secondary	18,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Harrogate Granby Park	52,000	Conventional	Sand	Chlorine Gas	—
Harrogate Woodlands	20,000	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	—
Harthill with Woodhall C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Hartwith Summerbridge	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Hebden Royd Centre, Pitt Street, Hebden Bridge	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Horbury C.E.	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Horbury Bridge C.E.	8,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Horsforth Featherbank	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969
Horsforth Training Centre	—	—	—	—	Pool in planning stage
Hoyland Common J.M.I.	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Ilkley Grammar	35,000	Conventional	Sand	Chlorine Gas	—
Ilkley Menston Primary	25,000	Constructed	Sand	Drip Feed	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Keighley Oakbank Grammar	60,500	Conventional	Diatoma- ceous Earth	Chlorine Gas	—
Kippax North C.P., Garforth Ninelands C.P., Garforth West C.P.	—	—	—	—	The Garforth and District Schools Sports Association have joint plans for these three schools
Kirkburton Training Centre	—	—	—	—	
Kirk Fenton Parochial	8,000	Learner	Sand	Automatic Chlorinator	—
Meltham C.E.	15,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Mexborough C.E.	9,600	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969
Mexborough Grammar	18,000	Learner	Diatoma- ceous Earth	Drip Feed	
Norton J. M.	8,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Ossett Comprehensive	—	—	—	—	Joint proposals with Ossett M.B. under review
Penistone St. John's C. E.	8,000	Learner	Canvas Bags	Drip Feed	Pool not used
Rawcliffe Training Centre	8,000	Learner	Sand	Automatic Chlorinator	
Ripon Grammar	52,000	Conventional	Sand	Chlorine Gas	—
Rothwell Carlton J.M.I.	8,000	Learner	Sand	Drip Feed	—
Scawthorpe Secondary	50,625	Conventional	Sand	Chlorine Gas	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Scholes J.M.I.	8,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Scissett Miners Welfare Club	70,000	Constructed	Sand	Chlorine Gas	Joint ownership with Denby Dale U.D.C.
Shade C.P. Todmorden	30,000	Conventional	Sand	Chlorine Gas	—
Sherburn in Elmet	8,000	Learner	Sand	Drip Feed	—
Stourton C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Swillington J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Tadcaster J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool under construction
Thorpe Arch C.E.	13,000	Conventional	Sand	Automatic Chlorinator	Pool opened 1969
Thorne Grammar	48,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Thrybergh J.M.	14,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969
Todwick J.M.	—	—	—	—	Pool in planning stage
Ulleskelf C.E.	6,000	Learner	Canvas Bags	Drip Feed	—
Upper Poppleton C.P.	2 pools 2,000 14,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Upper Wharfedale Secondary	43,000	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969
Upton - North Elmsall J.M.I.	21,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Wales C.P.	—	—	—	—	Pool in planning stage
Ward Green J.M.I., Worsbrough	12,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
West Ardsley Training Centre	—	—	—	—	Pool in planning stage
Weston Lane C.P., Otley	7,000	Constructed	Sand	Added by hand	—
Whinburn Special School, Keighley	5,000	Learner	Canvas Bags	Drip Feed	—
Whiston C.P.	8,000	Learner	Sand	—	Pool in planning stage
Worsbrough Bank End	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Worsbrough Birdwell C.P.	13,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1969

Table 69 Atmospheric Pollution

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High-est Value	Low-est Value	Average Daily Concentration SO ₂ *	High-est Value	Low-est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Barnoldswick—Health Department, Fernlea, surrounding district residential and commercial with railway nearby	77	376	2	76	500	10
Keighley—First floor of Public Health Department in built-up area in centre of town	84	304	6	145	1,015	28
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, $\frac{1}{4}$ mile south-west of town centre. Surrounding district residential	45	198	2	52	190	Alk.
Bingley—Health Department, Town Hall, $\frac{1}{5}$ th mile outside town centre, surrounding district parkland	45	214	5	94	337	6
Shipley—Health Department, Town Hall, surrounding district residential and commercial	60	331	6	148	496	27
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	50	441	2	121	515	15
Otley—First floor of Council Offices, in town centre, mainly manufacturing	68 for 11 months	279	3			
Pudsey (Stanningley)—“Southville”, Sunfield House, 20 ft. above ground on east side, surrounding district mainly industrial	62 for 9 months	588	7	141 for 9 months	652	12

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High-est Value	Low-est Value	Average Daily Concentration SO ₂ *	High-est Value	Low-est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Pudsey (Farsley)—Farfield House, Farfield Avenue, 20ft. above ground on north side, surrounding district residential	49 for 9 months	374	8	127 for 9 months	619	21
Pudsey (Calverley)—M. & C. W. Clinic, Chapel Street, 20ft. above ground on west side, surrounding district parkland and residential	52 for 9 months	381	4	125 for 9 months	567	18
Harrogate — Ground floor of Municipal Offices, surrounding district residential and commercial	49	285	3	87	320	0
Harrogate — Ground floor of Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	78	415	3	85	390	Alk.
Knaresborough—Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west	57	333	2	57	250	0
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	44	328	2	121	339	31
Castleford—First floor of Divisional Health Office, in residential area of industrial town	290 for 10 months	1,262	24	121 for 10 months	187	64

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	143	533	9	106	326	28
Castleford-Slaughterhouse in Superintendent's office, 20ft. above ground, surrounding district, residential and commercial	70 for 8 months	348	6	81 for 8 months	226	26
Normanton—Neville House. Surrounding district commercial, residential and a few small factories	161	937	10	165	701	35
Pontefract—Municipal Offices. In laboratory on second floor in mixed commercial and manufacturing area	123	706	12	162	768	32
Pontefract—Moverlay Flatts. In rear storeroom of Council Depot, surrounding district residential	149	562	17	168 for 11 months	588	41
Pontefract—Carleton Park. First floor landing of flats in residential area	86 for 11 months	587	10	124 for 11 months	541	31
Horbury—Ground floor lobby of Town Hall, facing east 12ft. above ground, surrounding district residential and manufacturing	72 for 10 months	602	11	150 for 10 months	870	14
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	97	429	12	137	603	0

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Morley—Spring Avenue, Gildersome in residential area	64	281	10	97	337	Alk.
Ossett—Seemore Arcade. Surrounding district residential and commercial	68	464	4	117	667	0
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	117	788	13			
Spenborough—Health Centre, Greenside, in small park, residential and commercial area	73	374	12	153	502	33
Elland—Council Offices, 20ft. above ground in manufacturing area	77	324	7	150	613	32
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	58	422	3	63	469	Alk.
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	92	387	9	112	520	13
Sowerby Bridge—Beech Road. Upper room of Public Health Department in a mainly residential area with some industrial plants 200 yards to east	64	418	3	127	759	0
Sowerby Bridge—Wharf Street. Situated on main Yorkshire—Lancashire road carrying heavy traffic, in a mainly commercial area	65	404	8	56 for 7 months	196	0

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	71	481	7	132	581	24
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	88	339	14	135	438	26
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	127	532	14	144	446	40
Denby Dale—Emley C.P. School. In village in open country	67	387	2	150	468	34
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	85	264	15	141	623	7
Kirkburton—Council Offices, Kirkheaton in residential area	127	591	15	152	825	30
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	100 for 7 months	465	10	80 for 7 months	256	Alk.
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	68	774	5	58	379	12
Wortley (Grenoside)—Health Dept., Council Offices, surrounding area industrial and manufacturing	69	302	2	107	354	6

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	49	319	4	87	322	0
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	115 for 6 months	566	7	83 for 6 months	295	6
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to S.E.	159 for 11 months	610	20	92 for 11 months	259	25
Wombwell—The Gables, semi-residential colliery district	200 for 11 months	768	19	133 for 11 months	372	35
Wombwell—The Library, Station Lane, surrounding district residential and commercial	173 for 11 months	662	29	130 for 11 months	303	60
Worsbrough—Savile House —8ft. above ground in out-building, rear of Council Offices. Surrounding country open and low density residential	124	442	10	97	303	18
Conisbrough—Denaby Clinic, in room facing north. Surrounding district residential —high density	128	457	9	147	416	33
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	119 for 11 months	1,078	7	121 for 11 months	440	38
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	221	1,147	18			

* For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Wath upon Dearne—Town Hall, in commercial and residential area with industrial zone 1-2 miles N. to N.E.	89	618	13	138	595	Alk.
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	98	436	19	116	321	44
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	62	387	3	90	347	13
Doncaster (Askern)—In Askern Clinic 6 miles south of Doncaster with open country to the south, residential to the north-east, heavy industry to north-west	66	445	2	175	836	24
Thorne—Council Offices, in semi-residential colliery district	82 for 9 months	401	5			

*For period of full year unless stated otherwise.

Table 70 Welfare of the Epileptic and Spastic—Particulars of known Epileptics and Spastics

	Number	
	Epileptics	Spastics
<i>Adults</i>		
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics 	65	
(b) in homes for spastics and other handicapped persons ...		24
(c) in County establishments and establishments where County Council has 'right of user' 	60	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) and not shown above 	177	246
<i>Children</i>		
Number ascertained as handicapped:		
(a) Approximate number attending ordinary schools 	not known	77
(b) Attending special schools 	20	95
(c) Receiving home tuition 		3
(d) Attending training centres for the mentally subnormal ...	106	76
Plus 26 children suffering from both epilepsy and spasticity		

Table 71 Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1969 of blind and partially sighted persons (other than handicapped school children.)

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retro-lental Fibroplasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(i) Number of cases registered during the year in respect of which Section F recommends:										
(a) No treatment 	89*	52†	41	4	—	—	104	59	234	115
(b) Treatment (medical, surgical, optical or ophthalmic medical supervision) 	148‡	139=	22	24	—	—	102	93	272	256
(ii) Number of cases at (i) (b) above who received treatment ...	80	103	19	21	—	—	84	81	183	205

* Includes 17 cases of cataract with glaucoma.
† Includes 2 „ „ „ „ „
‡ Includes 19 „ „ „ „ „
= Includes 26 „ „ „ „ „

Table 72 Residential Accommodation—(National Assistance Act, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
The Shroggs, Skipton Road, Steeton 	Miss V. Smith	Steeton 3213	20
Farfield Hall, Bolton Road, Addingham 	Mrs. S. A. Edwards	Bolton Abbey 241	30
Neville House, Neville Crescent, Gargrave 	Mr. and Mrs. S. Blackburn	Gargrave 349	34
Sharow View, Allhallowgate, Ripon 	Mr. and Mrs. E. Brook	Ripon 2238	73
The Beeches, Leeds Road, Tadcaster 	Mr. and Mrs. H. G. Jenner	Tadcaster 2113	111

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Wharfedale Lawn, Westgate, Wetherby	Miss L. Oliver	Wetherby 2446	20*
The Grove, 80, High Street, Starbeck	Miss W. Smeaton	Harrogate 83980	19*
Springfield Garth, York Road, Boroughbridge	Mr. and Mrs. H. S. Topliss	Boroughbridge 2189	34
Fircroft, Wighill Lane, Tadcaster... ..	Mrs. L. McLaughlin	Tadcaster 3204	27
Woodfield House, Woodfield Square, Harrogate	Mr. and Mrs. E. Drake	Harrogate 68728	34
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	191
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. D. Moor	Keighley 4014	123
Woodville, Spring Gardens Lane, Keighley	Mrs. C. Robinson	Keighley 2428	20
Crow Trees, Leeds Road, Rawdon	Mrs. J. Mitchell	Rawdon 2908	20
Burley Hall, Burley in Wharfedale	Mrs. D. Carling	Burley in Wharfedale 2334	27
Park House, 41, Lister Lane, Bolton, Bradford 2... ..	Mr. and Mrs. L. Gillard	Bradford 639913	22†
Moor Court, Fieldway, Ben Rhydding	Mr. and Mrs. C. A. Bennett	Ilkley 4734	34
Littlelands Court, Littlelands, Cottingley	Mr. and Mrs. T. Farrar	Bingley 5330	34
Manorfield House, Manor Road, Horsforth	Mr. and Mrs. G. Bevitt	Horsforth 3561	34
Heather Court, Main Street, Menston	Mr. and Mrs. W. Reilly	Menston 4813	34
Hall Croft, Church Street, Windhill, Shipley	Mr. and Mrs. H. Gledhill	Shipley 58071	34
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. J. Ellis	Elland 2985	35
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Saddleworth 4300	20

* Women only † Men only

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Thornhill Grange, Hanson Road, Rastrick	Mr. and Mrs. W. Corbett	Brighouse 4810	44
Heathlands, Meal Hill Lane, Slaithwaite	Mr. and Mrs. J. L. Raine	Slaithwaite 2856	34
Longlands, Leeds Road, Lightcliffe	Mrs. E. G. Iddon	Halifax 21254	20
Scaitcliffe Hall, Burnley Road, Todmorden	Mrs. N. M. Harris	Todmorden 2814	24
Scissett Mount, Busker Lane, Scissett	Mr. and Mrs. J. G. Raby	Skelmanthorpe 3260	34
Belle Vue House, Belle Vue Road, Shelf	Mr. and Mrs. R. Glew	Bradford 679011	34
Fieldhead, Fieldway, Shepley	Mr. and Mrs. K. Dixon	Kirkburton 3369	34
Brig Royd House, Halifax Road, Ripponden	Mr. and Mrs. J. R. D. Clee	Ripponden 3374	34
Greenacres, Huddersfield Road, Meltham	Mr. and Mrs. A. J. Kershaw	Meltham 669	34
Stanley View, Park Lodge Lane, Wakefield	Mrs. S. Radley	Wakefield 71016	177
Beech Towers, Halifax Road, Staincliffe, Dewsbury ...	Mr. and Mrs. N. W. Jones	Dewsbury 5691	237
Knowl Park House, Crow Lees Road, Mirfield	Mr. and Mrs. M. McEwan	Mirfield 2583	34
Knowle Manor, Tennyson Avenue, Morley	Mr. and Mrs. J. Brown	Morley 4740	34
Walton House, Shay Lane, Walton	Miss M. Manterfield	Wakefield 55242	20
Home Lea House, Wood Lane, Rothwell	Mr. and Mrs. H. Roberts	Rothwell 3218	34
Turnsteads, Whitcliffe Road, Cleckheaton	Miss J. E. L. Thwaites	Cleckheaton 2972	22
Brook Lodge, Brook Street, Selby	Mr. and Mrs. T. Bradley	Selby 2815	102
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. G. H. French	Pontefract 3351/2	142

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Parklands, Station Road, Rawcliffe	Mr. and Mrs. H. A. Silvester	Rawcliffe 226	34
Mill Garth House, Mill Hill Lane, Pontefract	Mr. and Mrs. J. T. Fenton	Pontefract 3593	44
Newfield, Brookfield Avenue, Pontefract Road, Castleford	Mr. and Mrs. W. G. Powell	Castleford 4110	34
Norman House, Attlee Street, Normanton	Mr. and Mrs. A. S. Huxley	Normanton 2366	34
Fearndale, Purston Park, Featherstone	Mr. and Mrs. C. W. Hutchinson	Pontefract 71642	34
Bullenshaw House, Bullenshaw Road, Hemsworth	Mr. and Mrs. R. A. Harris	Hemsworth 722	34
Langthwaite House, Barnsley Road, South Kirkby ...	Mr. and Mrs. J. A. Bromley	South Elmsall 2510	34
Highfield House, Love Lane, Castleford	Mr. and Mrs. G. Harrison	Castleford 3767	34
Boothferry House, Airmyn Road, Goole	Mr. and Mrs. M. J. Midgley	Goole 2471	34
Willow Grange, Fitzwilliam Street, Kinsley	Mr. and Mrs. E. Saddington	Hemsworth 371	34
Grange Court, Church Lane, Garforth	Mr. and Mrs. P. R. Dulley	Garforth 4845	34
Haynes House, Haynes Road, Thorne	Mr. and Mrs. C. Naylor	Thorne 3395	34
Don View, 22, Thellusson Avenue, Scawsby	Mr. and Mrs. W. R. Howells	Doncaster 2257	38
Rose House, Church Street, Armthorpe	Mr. and Mrs. M. Rogers	Armthorpe 450	34
Owston View, Lodge Road, Carcroft	Mr. and Mrs. A. Brearley	Adwick le Street 3368	34
Dearnlea, Park Road, Thurnscoe	Mr. and Mrs. J. M. Raine	Goldthorpe 3094	34
Rowena House, Old Road, Conisbrough	Mr. and Mrs. J. Harrison	Conisbrough 2331	34
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 2118	41

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Highfield, Woodsetts Road, North Anston	Mr. and Mrs. E. B. Stone	Dinnington 2593	34
Winterwell House, Dryden Road, West Melton ...	Mr. and Mrs. E. Bradley	Wath on Dearne 2096	34
Monkwood House, Whiteleys Avenue, Rawmarsh	Mr. and Mrs. W. Butler	Rawmarsh 2651	34
Howorth House, Brinsworth Lane, Brinsworth	Mr. and Mrs. J. C. Milne	Rotherham 3373	34
Oaklands, Oakdale, Worsbrough Bridge	Mr. and Mrs. A. Wild	Barnsley 5529	41
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. C. Stoney	Penistone 2144	(2
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 2186	17*
Mortomley House, High Green	Mr. and Mrs. G. A. Smith	High Green 323	45
Oakwood, Back Lane, Royston	Mr. and Mrs. J. Wakeling	Royston 2725	34
Carlton House, Carlton Street, Cudworth	Mr. and Mrs. J. Lodge	Cudworth 389	34
Charnwood House, Charnwood Street, Swinton	Mr. and Mrs. J. Carroll	Mexborough 2236	34
Starbeck House, 35 Avenue Close, Starbeck	Mr. and Mrs. E. Hubbick	Harrogate 86940	34
Sowood Grange, Horbury Road, Ossett	Mr. and Mrs. J. Gant	Ossett 3105	34
Eddercliffe Grange, Littleton, Liversedge	Mr. and Mrs. R. C. Cost	Cleckheaton 4803	34
Yew Tree House, Askern Road, Bentley	Mrs. S. G. Kenny	Doncaster 54620	34
Oldfield House, Oldfield Lane, Stainforth	Mr. and Mrs. V. Horne	Stainforth 753	34
Water Royd House, Gilroyd, Dodworth	Mr. and Mrs. A. Heathcock	Barnsley 81389	34
Kershaw Grange, Kershaw Crescent, Luddendenfoot ...	Mr. and Mrs. G. Deacon	Calder Valley 2506	34
Green Park House, High Street, Pensitone	Mr. and Mrs. P. Hale	Penistone 2000	34
Havenfield, Highfield Road, Darfield	Mr. and Mrs. G. C. Waite	Wombwell 3111	34

* Women only

Table 73 Registration and Inspection of Disabled and Old Persons' Homes—
(National Assistance Act, 1948)

Establishment	Number of Resi- dents	Type of Home *(Part I, II or III)
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster	34	I
Harrogate Old People's Home, 66-68, Cold Bath Road, Harrogate ...	36	I
Ernest Ayliffe Home for the Deaf and Dumb, Fulford Grange, Rawdon	32	II
North Regional Association for the Blind, "Oaklands," Huddersfield Road, Holmfirth	30	II
Keighley & District Institute for the Blind, 13-15, Scott Street, Keighley	28	II
Mrs. M. L. Harris, The Woodlands, Farrer Lane, Oulton	21	I
Methodist Homes for the Aged, "Glen Rosa," Grove Road, Ilkley...	32	I
Methodist Homes for the Aged, Berwick Grange, 5, Otley Rd., Harrogate	34	I
Highfield Home for the Blind, Soothill Lane, Batley	14	II
Catholic Women's League, Clitherow House, 49, Valley Dr., Harrogate	16	I
Miss L. W. Miller, "Greylands," Forest Moor, Knaresborough ...	7	I
Mr. E. Fowler, Haversham Court, Ben Rhydding Road, Ilkley ...	26	III
Mr. R. E. and Mrs. F. I. Quirk, Gratton Home for Aged Ladies, 11, East View Terrace, Otley	18	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	13	I
Mrs. A. Carter-Squire, "Newlands," 58, Harlow Moor Drive, Harrogate	9	I
Yorkshire Association for the Disabled, St. George's House, Otley Road, Harrogate	108	II
Mr. J. N. and Mrs. A. M. Gill, The Gables, Norland, Sowerby Bridge	11	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley	5	I
Mrs. M. R. Dodds, Lansdown, 30, Westcliffe Grove, Harrogate ...	8	I
Mr. and Mrs. G. North, "Burnlee House," Park Head, Holmfirth ...	17	I
Mrs. Minnie Satariano, "Downside," 15, Otley Road, Harrogate ...	15	I
Mrs. Alice McConney, Elm Bank, 242, Park Lane, Keighley ...	8	I
Mr. Douglas Kneen, Thorpe House, Triangle, near Halifax	16	I
Mrs. Doreen May Thompson, Brooklands, Harper Lane, Yeadon ...	6	I
Mrs. R. E. Higgins, Housley Manor, Housley Hall Lane, Chapeltown	16	I
Pentecostal Eventide Housing Association, Brooklands, Bakewell, Pentecostal Eventide Home, Bradford Road, Wrenthorpe	30	I
Mrs. Hester Walker, Granville House, Exley Road, Keighley ...	9	III
Mrs. A. G. Turner and Miss G. Carradice, Ghyll Court, The Wells Walk, Ilkley	22	I
Mrs. K. M. Pay, 60, Franklin Road, Harrogate	7	I
Mr. F. Vasey (Kildare Lodge Ltd.), Kildare Lodge, 23, Park Drive, Harrogate	9	I
Mr. J. Perry, Hartwell Home, Raincliffe, Thorpe Hesley	22	I
Mrs. Freda Mary Hodge, The Redlands, 21, Grove Road, Harrogate	6	I
Keighley and District Institution for the Blind, Home for the Blind, Westfield, Bromley Road, Bingley	16	II
Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon	18	I
Mrs. Dorothy Pearson, Thornlea Villas, Holme House Road, Cornholme, Todmorden	6	I
Mrs. L. Lawrence, Fearby House, 77, High Street, Starbeck, Harrogate	6	I
Mr. Geoffrey Noble and Mrs. Brenda Ainsworth, Bankfield Guest House, Hollins Lane, Sowerby Bridge	13	I

Establishment	Number of Resi- dents	Type of Home *(Part I, II or III)
Mrs. B. Townend, Lyndon Rest Home, 30, Ripon Road, Harrogate...	10	I
Pudsey Voluntary Committee for the Welfare of the Blind, Lynnwood Centre and Residential Home, 18, Alexandra Road, Pudsey ...	9	II
Mrs. A. McConney, "Christony," Beech Grove, Sutton in Craven ...	12	I
Sue Ryder Home for Concentration Camp Survivors, Hickleton Hall, Nr. Doncaster	27	III
Mrs. Hilda Mary Dobson, Carr Farm, Darley, Nr. Harrogate ...	5	I
Mrs. W. G. Pickering, "Fairholme," Hebers Ghyll Drive, Ilkley ...	8	I
Mrs. M. Jowett, Valley View Rest Home, 4, Cross Banks, Otley Road, Shipley	8	I
Mrs. Doris Jervis, Straymeade, 38, York Place, Harrogate	11	I
Dr. A. and Mrs. I. M. Grenville-Wood, Regis House, 16, Roseville Road, Harrogate	5	I
Mr. and Mrs. T. H. Horsfall, The Woodlands, Gelderd Road, Gilder- some	20	I
Mr. and Mrs. A. K. Sims, Oaklands, Turnshaw Road, Kirkburton, Huddersfield	26	III
Mrs. C. Holmes, Hill Crest, 40, Harlow Moor Drive, Harrogate ...	10	I
Mrs. E. White and Mr. J. Shilson, Park Lodge Rest Home, 34, Park Avenue, Harrogate	12	I
Mr. and Mrs. J. C. Van Der Velde, Waldernheath Hotel for the Elderly, 60, Cornwall Road, Harrogate	38	I
Mrs. K. Gregg, Wyndcliffe, Wilton Road, Ilkley	9	I
Mrs. N. Cassells, 9, Whitcliffe Crescent, Ripon... ..	6	I
Miss A. Watson, 1, Mayfield Villas, Kirklands Road, Baildon ...	4	I
Miss M. R. Murison, 10, Regal Flats, Clarence Drive, Harrogate ...	3	I
Mrs. P. H. Booth, Fellstow, 5, Clifton Road, Ilkley	15	I
The Management Committee of the West Riding Cheshire Homes, White Windows, Sowerby Bridge	35	III
Mr. and Mrs. C. Morritt, Welland Villa, 53, Richardshaw Lane, Pudsey	7	I
Mr. A. S. Burch, Meralda Hotel, 13-15, Grove Road, Harrogate ...	14	I
Mrs. M. A. Lund, The Borrins, Station Road, Baildon	17	I
Mrs. J. M. Barker, Ivy Bank, 162, Highfield Lane, Keighley	5	I
Mr. A. J. and Mrs. A. S. Lee, Springfield, 3 Lowther Avenue, Garforth	12	I
Mrs. D. Wilson, Wilsonia Rest Home, 51, Tewitt Well Road, Harrogate	6	I
Mrs. M. G. Harker, North Villa House, 155, Skipton Road, Keighley...	8	I
The Management Committee of the West Riding, Cheshire Homes, Champion House, Clara Drive, Calverley, Pudsey	11	III
Mr. D. and Mrs. D. A. Hodgson, Ferndale Residential Home for the Elderly, Britannia Road, Morley	3	III
Clement Birkinshaw Home for the Elderly, Wooley Moor House, Woolley Moor, Near Wakefield	21	I
Mr. W. C. and Mrs. M. Snelling, Kingsley House Gentlefolk's Home, 40, Ripon Road, Harrogate	9	I
<i>Incorporated by Royal Charter</i>		
Lister House, Sharow, near Ripon	70 approx.	III (and Hospital cases)

* Part I—Homes for Old Persons.
 Part II—Homes for Disabled Persons.
 Part III—Homes for Old and Disabled Persons.

Table 74 Registration of Nursing Homes

Div. No.	Name and Address of Nursing Home	Number of beds registered	
		Maternity	Other
1	“ Christony ”, Eshton Hall, Gargrave	—	26
3	Sunnybank, Braithwaite, Keighley	—	9
3	Norwood House, High Spring Gardens Lane, Keighley ...	—	14
4	Elmhurst, Hall Bank Drive, Bingley	—	3
4	Thornfield, Micklethwaite, Bingley	—	11
5	Oak Bank, Outwood Lane, Horsforth	—	10
5	Jesmond, New Street, Farsley	—	7
5	St. Joseph’s Convalescent Home, Outwood Lane, Horsforth...	—	45
5	Ardenlea, Queen’s Drive, Ilkley (Marie Curie Memorial Foundation)	—	33
5	Hanford House, 22, Margerison Road, Ben Rhydding, Ilkley	—	7
7	Cavendish, 17, Cavendish Avenue, Harrogate... ..	—	16
7	Duchy House, 9, Queen’s Road, Harrogate	—	35
7	The Pines, 57, Harlow Moor Drive, Harrogate	—	14
7	Norman Lodge, 58, Kent Road, Harrogate	—	29
7	Westfield, Killinghall, Harrogate	—	9
7	Courtfield, 3, St. James’s Drive, Harrogate	—	14
7	Hereford, 16, Hereford Road, Harrogate	—	22
7	Strathroy, 115, Franklin Road, Harrogate	—	6
7	Kingsley, 38, Ripon Road, Harrogate	—	26
7	Ellangowan, 26, Queen’s Road, Harrogate	—	16
7	Clova, 1, Clotherholme Road, Ripon	—	21
7	Heatherwood, 17, Duchy Road, Harrogate	—	14
7	Hampden House, 120, Duchy Road, Harrogate	—	46
7	Edenfield, 3, Tewit Well Road, Harrogate	—	32
9	Cheshire Home, Spofforth Hall, Spofforth, Harrogate ...	—	28
15	Cheshire Home, Kenmore, Whitcliffe Road, Cleckheaton ...	—	27
20	Woodend, Atherton Street, Springhead	—	13

Table 75 The Medical Inspection of School Children

NUMBER OF PUPILS ON REGISTERS

							Boys	Girls	Total
Nursery	...	...	...	...	...	...	361	312	673
Primary	...	...	...	...	...	...	96,922	92,654	189,576
Secondary	...	...	...	...	...	...	58,849	55,710	114,559
Special Schools (Boarding)	...	...	...	...	...	...	247	118	365
Special Schools (Day)	...	...	...	...	...	...	523	409	932
Special Schools (Hospital)	...	...	...	...	...	...	49	36	85

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each, together with classification of the physical condition of the pupils inspected.

Age groups inspected (Year of Birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination (See Note below)
		Satisfactory No.	Unsatisfactory No.	
(1)	(2)	(3)	(4)	(5)
1965 and later	3,319	3,316	3	—
1964	16 561	16 534	27	—
1963	10,630	10,609	21	100
1962	2 459	2,458	1	629
1961	3,234	2 228	6	4,086
1960	2,330	2,327	3	3,161
1959	1,278	1,278	—	2,678
1958	1,686	1,670	16	2,711
1957	1,290	1 289	1	3,451
1956	444	444	—	2,257
1955	3,211	3,187	24	2,987
1954 and earlier	5,323	5,305	18	5,855
Total	51,765	51 645	120	27,915

Column (3) total as a percentage of Column (2) total ... 99·77

Column (4) total as a percentage of Column (2) total... 0·22

NOTE: As selective examinations have been carried out, Column (5) above gives the number of pupils who have been “interviewed” or “discussed” at case conferences and found not to warrant a medical examination.

B.—Other Inspections

Number of Special Inspections	12,830
Number of Re-Inspections ...	8,668
Total ...	21,498

The number of children examined during 1969 shows a decrease on the 1968 figures:

Year	Periodics	Other Inspections	Number of pupils found not to warrant an examination on Selective Procedures
1968	59,315	20,784	17,091
1969	51,765	21,498	27,915

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of Birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total individual pupils
1965 and later	45	138	161
1964	402	1,240	1,543
1963	371	992	1,253
1962	100	225	292
1961	167	416	519
1960	106	231	307
1959	86	114	179
1958	116	189	263
1957	81	153	218
1956	21	36	53
1955	192	368	533
1954 and earlier	326	423	705
Total	2,013	4,525	6,026

TABLE II
INFESTATION WITH VERMIN

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	425,329
(ii) Total number of individual pupils found to be infested	7,243
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	185
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	15

The percentage of infested pupils found during 1969 was 1.70 as opposed to a percentage of 1.78 in 1968.

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1969

NOTE.—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS						SPECIAL INSPECTIONS	
		Entrants		Leavers		TOTAL (including all other periodic age groups inspected)		Requiring treatment	Requiring observation
		Requiring treatment	Requiring observation	Requiring treatment	Requiring observation	Requiring treatment	Requiring observation		
4	Skin	242	713	325	207	718	1,146	325	243
5	Eyes— a. Vision b. Squint c. Other	927 350 36	1,864 634 124	554 33 10	783 86 76	2,094 456 66	3,311 879 254	394 91 19	1,247 255 43
6	Ears— a. Hearing b. Otitis Media c. Other	245 109 29	976 558 182	60 31 11	113 72 29	457 167 54	1,467 754 251	242 37 51	547 176 60
7	Nose and Throat	451	1,775	62	169	665	2,288	161	573
8	Speech	310	802	13	31	409	996	200	307
9	Lymphatic Glands	19	571	—	18	24	659	8	121
10	Heart	81	496	10	69	122	750	16	302
11	Lungs	135	669	28	104	242	1,035	116	338
12	Developmental— a. Hernia b. Other	55 85	122 764	3 52	11 53	66 208	158 1,002	5 60	51 325
13	Orthopaedic— a. Posture b. Feet c. Other	19 170 60	105 619 443	4 74 27	57 115 104	40 329 106	208 911 656	7 96 67	52 306 239
14	Nervous System— a. Epilepsy b. Other	35 54	90 508	20 16	27 61	73 128	179 750	51 30	69 172
15	Psychological— a. Development b. Stability	74 47	371 756	11 17	36 95	136 120	620 1,248	349 308	365 454
16	Abdomen	35	125	16	29	77	218	24	71
17	Other	236	876	78	81	437	1,175	130	591

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:

- (i) cases treated or under treatment during the year by members of the Authority's own staff;
- (ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Boards;
- (iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Figures under this section are incomplete as one has to rely on hospital discharge notifications and other agencies.

								Number of cases known to have been dealt with
<i>Group 1. Eye Disease, Defective Vision and Squint</i>								
External and other, excluding errors of refraction and squint								1,993
Errors of refraction (including squint)								18,059
Total								20,052
Number of pupils for whom spectacles were prescribed								7,221
								Number of cases known to have been treated
<i>Group 2. Diseases and Defects of Ear, Nose and Throat</i>								
Received operative treatment:								
(a) for diseases of the ear								85
(b) for adenoids and chronic tonsillitis								1,232
(c) for other nose and throat conditions								126
Received other forms of treatment								275
Total								1,718
Total number of pupils in schools who are known to have been provided with hearing aids:								
(a) in 1969								46
(b) in previous years								248
<i>Group 3. Orthopaedic and Postural Defects</i>								
(a) Pupils treated at clinics or out-patient departments								576
(b) Pupils treated at school for postural defects								59
Total								635

										Number of cases known to have been treated
<i>Group 4. Diseases of the skin (excluding uncleanliness for which see Table II)</i>										
Ringworm—(a) Scalp	...	...	...	...	...	...	...	...	...	8
(b) Body	...	...	...	...	...	...	...	...	...	14
Scabies	...	...	...	...	...	...	...	...	...	971
Impetigo	...	...	...	...	...	...	...	...	...	303
Other skin diseases	...	...	...	...	...	...	...	...	...	758
Total										<u>2,054</u>
<i>Group 5. Child Guidance Treatment</i>										
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority										2,220
<i>Group 6. Speech Therapy</i>										
Number of pupils treated by Speech Therapists under arrangements made by the Authority										2,313
<i>Group 7. Other Treatment Given</i>										
(a) Number of cases of miscellaneous minor ailments treated by the Authority										1,614
(b) Pupils who received convalescent treatment under School Health Service arrangements										11
(c) Pupils who received B.C.G. vaccination										19,979
(d) Other:										
1. Ultra Violet Light Treatment										29
2. Remedial Exercises										41
3. Audiology										152
4. Abdominal defects										20
5. Chest and Heart										63
6. Miscellaneous										181
Total (a)—(d)										<u>22,090</u>

Table 76 Care of the Handicapped Pupil

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year:

Category	New Ascertainments	New Placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	No. Attending Independent Schools	No. Awaiting Placement in Special Schools	No. receiving Home Tuition
			Day	Board- ing				
Blind	3	6	—	52	—	—	3	1
Partially Sighted	7	7	27	22	—	—	7	—
Deaf	15	12	49	106	—	—	6	—
Partially Hearing	13	10	33	42	—	—	6	—
Delicate	57	48	18	97	2	—	4	1
*Physically Handicapped	66	65	115	133	1	13	21	30
Educationally Subnormal	375	382	1,154	235	—	18	228	1
Maladjusted	32	22	—	59	19	7	26	5
Epileptic	4	4	—	19	—	—	—	—
Speech Defects	1	3	1	3	—	—	1	1
Totals	573	559	1,400	768	22	38	302	39

* Excluding children sent to or awaiting places in hospital schools.

Table 77 Educable Children Suffering from Cerebral Palsy

The following table gives the details relating to educable cerebral palsied children in the West Riding including children of pre-school age:

Total No. of educable Spastics	No. accom- modated in Special Schools	No. attending Ordinary Schools		No. receiving Home Tuition	No. receiving no Education
		Satisfactorily	Needing placement in Special Schools		
179	95	54	23	3	4

Otley Clinic

SUMMARY OF WORK CARRIED OUT

<i>Number of Sessions held</i>	6
<i>Number of Individual Children attending</i>	
(a) Referred for first time in current year...	7
(b) Also attended in previous year	8
Total	15
<i>Total number of attendances made</i>	21
<i>Areas from which referred (i.e. number from each Division)</i>	
Division No. 4	1
Division No. 5	14
Total	15
<i>Ages of children referred</i>	
Under 1	—
1—2 years	2
2—5 years	1
5—8 years	6
8—11 years... ..	3
11+ years	3
<i>Results of Clinical Investigation</i>	
Number of children with significant hearing loss	11
Number of children without significant hearing loss	4
<i>Recommendations</i>	
Hearing aid... ..	2
To sit in front of class	3
Speech Therapy	—
School for Deaf	—
School for Partially Hearing	1
School for Speech Defects	—
School for E.S.N.	1

Number of Sessions held	...	...	...	...	...	...	38
Number of Individual Children attending							
(a) Referred for first time in current year...	...	...	...	...	...	...	90
(b) Also attended in previous year	...	...	...	...	...	...	59
Total							149
Total number of attendances made							
...	...	...	...	...	...	...	172
Areas from which new cases referred (i.e. number from each Division)							
Division No. 11	...	...	...	...	...	...	4
Division No. 12	...	...	...	...	...	...	2
Division No. 13	...	...	...	...	...	...	1
Division No. 23	...	...	...	...	...	...	6
Division No. 25	...	...	...	...	...	...	1
Division No. 26	...	...	...	...	...	...	3
Division No. 27	...	...	...	...	...	...	68
Division No. 29	...	...	...	...	...	...	1
Division No. 31	...	...	...	...	...	...	4
Total							90
Ages of children referred in current year							
Under 1	...	...	...	...	...	...	7
1—2 years	...	...	...	...	...	...	9
2—5 years	...	...	...	...	...	...	14
5—8 years	...	...	...	...	...	...	38
8—11 years...	...	...	...	...	...	...	16
11+ years	...	...	...	...	...	...	6
Results of Clinical Investigation							
Number of children with significant hearing loss	...	...	...	...	...	...	59
Number of children without significant hearing loss	...	...	...	...	...	...	76
Number of children at present undiagnosed	...	...	...	...	...	...	14
Recommendations							
Hearing aid...	...	...	...	...	...	...	6
Front seat in class	...	...	...	...	...	...	8
Speech therapy	...	...	...	...	...	...	7
School for the Deaf	...	...	...	...	...	...	6
School for the Partially Hearing	...	...	...	...	...	...	1
Referred to E.N.T. Consultant	...	...	...	...	...	...	25
Referred to Child Guidance Clinic	...	...	...	...	...	...	1
For Supervision for Peripatetic Teacher	...	...	...	...	...	...	13
To be seen by Psychologist	...	...	...	...	...	...	27
To spend half a day in the Nursery	...	...	...	...	...	...	9
Department of the Y.R.S.D.	...	...	...	...	...	...	9

DONCASTER AUDIOLOGY CLINIC

Report by the Medical Officer in Charge—Dr. J. Ferguson

The attendance at the clinic continued at a constant level. It is interesting to note that thirty out of ninety new cases were under the age of five years. The new acoustic impedance meter is proving of value as an aid to diagnosis of secretory otitis or 'gluey' ear. A report of all investigations and the result of all tests are sent to the E.N.T. Consultant where operative treatment may be possible or where a hearing aid may be necessary. It is now possible to include the graph and results of the impedance meter tests to help the Consultant. The help and co-operation of the Peripatetic Teacher continues to be most valuable. Nine sessions per week have now been allocated.

My thanks are again due to the enthusiastic staff of the clinic who work with me.

Table 79 The Work of the Psychologists

CHILDREN SEEN
Maladjusted

		Age Range				
		below 5	5—7+	8—10+	Over 11	Totals
Boys	...	12	136	178	204	530
Girls	...	7	48	69	99	223
Totals	...	19	184	247	303	753
% age	...	2.5	24.5	32.8	4.02	

Symptoms on Referral

		Nervous	Behaviour	Habit	Others	Totals
Boys	...	119	355	43	23	540
Girls	...	67	122	26	8	223
Totals	...	186	477	69	31	763
% age	...	24.4	62.5	9.0	4.1	

Sources of Referral

	S.M.O.	H.T.	G.P.	Pæd.	P.O.	C.O.	Parent	Others	Totals
	112	188	122	21	15	14	30	20	622
% age	34.0	32.0	19.6	3.3	2.4	2.3	4.8	3.4	

Children with Handicaps other than Maladjustment referred for Psychological Assessment

Age Range

		below 5	5—7+	8—10+	Over 11	Totals
Boys	...	53	213	287	114	667
Girls	...	45	95	110	44	294
Totals	...	98	308	397	158	961
% age	...	10·2	32·0	41·3	16·5	

Type of Handicap

		Vision	Hearing	Speech	Motor	Learning	General Back-wardness	Others	TOTALS
Boys	...	10	71	35	47	272	226	14	675
Girls	...	8	27	11	19	87	136	8	296
Totals		18	98	46	66	359	362	22	971

Sources of Referral

S.M.O.	H.T.	G.P.	Pæd.	Parent	Others	Totals
361	348	26	34	19	46	834

VISITS

Schools	Special Schools	T.C.	Homes	Aud. Clinics	Others
796	152	31	87	36	30

Table 80 School Ophthalmic Service, 1954-69

Year	No. of children examined (including re-examinations)	No. prescribed glasses
1955	17,265	9,926
1956	17,644	9,999
1957	17,662	9,782
1958	18,829	9,472
1959	18,784	9,411
1960	20,651	10,029
1961	20,387	9,542
1962	19,874	8,831
1963	20,559	9,201
1964	20,248	8,904
1965	20,304	8,590
1966	19,996	8,024
1967	20,167	7,649
1968	20,725	7,747
1969	20,052	7,221

Table 81 Medical Treatment at Clinics

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	75	—
Dental	63	—
Ophthalmic	8	52
Speech Therapy	53	—
Ultra Violet Light	2	—
Pædiatric	11	7
Chiropody	2	—
Consultant E.N.T.	—	7
Consultant Orthopædic	3	10
Consultant Dermatology	—	1
Consultant Cardiac	—	2
Orthoptic	—	5
Remedial Exercises... ..	15	—
Audiology	2	—
Immigrants	1	—

Table 82 Consultant Services

CONSULTANT E.N.T. SERVICE

No. of sessions held: 87

	Pre-school Children	School Children	Total
No. of individual children seen by consultant, including those continuing attendance from previous year 	12	287	299
No. of above referred for operative treatment	9	118	127
No. of children:			
(a) who obtained operative treatment ...	5	242	247
(b) treated at school clinics 	—	36	36
No. of attendances at consultant clinics ...	15	569	584

CONSULTANT ORTHOPÆDIC SERVICE

Consultant Clinic

No. of sessions held: 155

No. of individual patients seen by consultant, including those continuing attendance from previous year 	421	621	1,042
No. of above:—			
(a) referred for operative treatment as short stay cases only 	6	10	16
(b) recommended long-stay hospital school	—	1	1
(c) recommended treatment by orthopædic nurse or physiotherapist:—			
(i) at treatment centres 	11	40	51
(ii) domiciliary 	4	13	17
No. of children who obtained operative treat- ment 	4	7	11
Total number of attendances at consultant clinics 	570	799	1,369

Treatment Centres

No. of sessions held: 797

Total No. of patients treated, including cases continuing treatment from previous year ...	71	265	336
Total number of attendances 	743	2,889	3,632

Domiciliary Treatment

	Pre-school Children	School Children	Total
Total number treated	9	—	9
Total number of visits to patients' homes ...	57	—	57

Appliances

No. of appliances—			
(a) recommended	64	24	88
(b) obtained	55	23	78

PHYSIOTHERAPY SERVICE

At the end of the year the staff aggregated the equivalent of 0·94 whole-time officers.

ULTRA-VIOLET LIGHT CLINICS

Clinics are held in only two Divisions.

Number of sessions held: 156

Number of children treated during the year ...	4	29	33
Total number of attendances	51	545	596

CONSULTANT PÆDIATRIC SERVICE

Consultant Clinics

No. of sessions held: 139

No. of individual patients seen—			
(a) New cases	93	92	185
(b) Cases attending from previous year(s) ...	197	318	515
Total number of attendances at clinics ...	354	499	853

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:

Defect or Disease	Pre-School Children	School Children	Total
Central Nervous System: General	20	17	37
Epilepsy	11	28	39
Migraine	—	17	17
Other defects	—	2	2
Heart and Circulatory System	23	67	90
Respiratory System, including E.N.T. defects	17	44	61
Speech	4	9	13
Orthopædic	5	—	5
Scaphocephaly	—	1	1
Cerebral Palsy	—	1	1
Skin	7	3	10
Psychological: General	1	5	6
Enuresis	—	2	2
Behaviour	—	1	1
Mental Retardation, including Educational			
Subnormality	16	17	33
Congenital Deformities	6	4	10
Gastro-intestinal System	7	1	8
Genito-urinary System	2	2	4
Glands	4	4	8
Nutritional	4	7	11
Developmental: General	65	43	108
Incontinence	2	20	22
Genetic undersize	—	—	—
Muscular Disease	2	8	10
Habit Spasms	1	3	4
Rheumatism	—	1	1
Obesity	—	2	2
Degeneration of macula and optic atrophy...	1	—	1
Unclassified	28	15	43

Table 83 Cleanliness, 1951-69

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
1951	559,388	18,599	7.9
1952	610,201	19,772	8.1
1953	575,645	17,815	7.1
1954	549,961	13,619	5.3
1955	547,369	11,657	4.5
1956	512,868	10,379	3.9
1957	481,239	10,459	3.9
1958	523,353	9,753	3.7
1959	482,874	9,834	3.6
1960	467,937	10,341	3.9
1961	462,207	9,273	3.5
1962	421,257	8,912	3.3
1963	416,570	8,229	3.3
1964	434,790	8,696	2.0
1965	461 862	8,999	3.2
1966	478,017	7,786	2.7
1967	455,124	7,119	2.4
1968	446,713	7,980	2.6
1969	425,329	7,243	2.3

In some areas a system of ‘Selective ’ inspections has been introduced as suggested in *The Health of the School Child*, 1962/63.

Table 84 Nutrition, 1958-69

Year (1)	Total number of pupils inspected (2)	Classification			
		Satisfactory		Unsatisfactory	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
1958	84,346	83,025	98·43	1,321	1·57
1959	88,398	87,484	98·97	914	1·03
1960	83,630	82,892	99·12	738	0·88
1961	82,938	82,343	99·28	595	0·72
1962	82,395	81,950	99·46	445	0·54
1963	76,706	76,268	99·43	438	0·57
1964	70,895	70,485	99·42	410	0·58
1965	75,134	74,728	99·46	406	0·54
1966	73,122	72,836	99·61	286	0·39
1967	68,382	68,264	99·83	118	0·17
1968	59,315	59,187	99·78	128	0·22
1969	51,765	51,645	99·77	120	0·23

SCHOOL MEALS

The number of meals provided to school children daily according to a check made in September, 1969 was 209,484 compared with 205,394 in September, 1968. This represents 76·75 per cent. of children in attendance.

Table 85 Protection of School Children Against Tuberculosis
TUBERCULIN TESTING OF SCHOOL ENTRANTS

Health Division (a)	No. tested (b)	Negative reactions (c)	Positive reactions (d)	Of column (d)		Further investigation
				Previous B.C.G. Vaccina- tion	Final Skin Test — +	
Keighley (Heaf Test)	759	751	8	6	— 2	Referred to Chest Physician.

Table 86 Speech Therapy

(a) Number of children seen for the first time during the year 	1,303	
(b) Number of children attending for treatment from previous year ...	1,010	
	2,313	
Number of children awaiting treatment at end of year 	836	
(a) Interviewed and placed on waiting list 	371	
(b) Not seen	475	
Number of visits made to schools 	351	
Number of home visits 	54	
Analysis of children treated	<i>Boys</i>	<i>Girls</i>
Stammerers (Dysrhythmia)	232	50
Defects of Articulation due to:		
(a) Cleft Palate 	31	19
(b) Cerebral Palsy 	11	11
(c) Other structural malformations 	27	31
(d) Other causes e.g. neurological 	39	6
(e) No specific cause found 	832	367
Disorders of Language due to:		
(a) Retarded language development (non-specific) 	208	106
(b) Retardation with associated subnormality 	125	66
(c) Retardation associated with deafness 	41	25
(d) Dysphasia 	9	3
(e) Aphasia 	3	1
(f) Other reason 	11	1
Dysphonia 	4	3
Other Defects 	11	3

Table 87 Dental Inspections and Treatment Carried Out

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	29,317	28,869	5,897	64,083
Subsequent visits	32,737	62,928	13,468	109,133
Total visits	62,054	91,797	19,365	173,216
Additional courses of treatment commenced	1,311	1,852	460	3,623
Fillings in permanent teeth ...	35,465	85,487	20,173	141,125
Fillings in deciduous teeth ...	18,867	1,631	—	20,498
Permanent teeth filled	26,506	72,793	17,709	117,008
Deciduous teeth filled	16,869	1,508	—	18,377
Permanent teeth extracted ...	2,701	10,634	2,224	15,559
Deciduous teeth extracted ...	45,412	11,266	—	56,678
General anæsthetics	15,419	7,458	748	23,625
Emergencies	2,415	1,198	297	3,910
Number of Pupils X-rayed				3,497
Prophylaxis				18,198
Teeth otherwise conserved				2,168
Number of teeth root filled				283
Inlays				96
Crowns				506
Courses of treatment completed... ..				52,336

Orthodontics

Cases remaining from previous year ...	3,885
New cases commenced during year ...	1,301
Cases completed during year	1,076
Cases discontinued during year	158
Number of removable appliances fitted...	2,534
Number of fixed appliances fitted ...	93
Pupils referred to Hospital Consultant ...	—

Prosthetics

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	3	6	7	16
Pupils supplied with other dentures (first time)	33	210	129	372
Number of dentures supplied	53	362	251	666

Anæsthetics General Anæsthetics administered by Dental Officers ...	23,163
--	--------

Inspections

(a)	First inspection at school. Number of Pupils ...	...	...	...	173,385
(b)	First inspection at clinic. Number of Pupils ...	...	...	...	18,563
	Number of (a) + (b) found to require treatment	...	...	...	109,197
	Number of (a) + (b) offered treatment ...	...	...	...	96,702
(c)	Pupils re -inspected at school or clinic...	...	...	...	18,447
	Number of (c) found to require treatment	...	...	...	9,087

Sessions

Sessions devoted to treatment	23,384*
Sessions devoted to inspection	...	...	...	1,269
Sessions devoted to Dental Health Education	...	...	...	443

*Includes 1,542 Anaesthetic sessions

FOOD AND DRUGS ACT, 1955

Report of County Analyst

During the year, 2,740 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out below:

	Total Samples	Adulterated or Below Standard	Percentage Adulterated or Below Standard
Milk	1,072	33	3·1
Milk, Channel Islands ...	164	4	0·2
Milk, Bottle	1	1	100·0
Milk and Foreign Matter ...	1	1	100·0
Food and Drugs	1,502	67	4·5
All samples	2,740	106	3·9

NOTES ON ADULTERATED OR OTHERWISE IRREGULAR SAMPLES:

The proportion of adulterated and irregular samples as shown in the above summary is 3·9 per cent. This is slightly above last year's figure, but it does not compare unfavourably with those of other Authorities.

Milk. Out of 1,072 samples, 33 were unsatisfactory; 21 were deficient in fat in amounts varying between 2·3 per cent. and 47·3 per cent. Twelve other samples contained between 0·8 per cent. and 9·7 per cent. of added water.

Channel Islands Milk must contain at least 4·0 per cent. of fat. Four samples were below standard, with 3·46 per cent. as the lowest fat content. One of these also contained 3·6 per cent. of added water.

Sausages. The Sausage and Other Meat Product Regulations, 1967, came into force on May 1st, 1969, thus establishing standards which had been recommended and applied by public analysts for many years. These had often been challenged by manufacturers, although the majority observed these standards and welcomed their enforcement. Now pork sausage must contain at least 65 per cent. of meat, and beef sausage at least 50 per cent. of meat.

Eighty-five samples of pork sausage and pork sausage meat were examined; eight were deficient in meat and four others contained preservative without proper declaration of the fact. The average meat content was 71·3 per cent., the lowest being 52·0 per cent., the highest 90·2 per cent.

We received 80 samples of beef sausage and beef sausage meat. These all complied with the Regulations as regards meat content, but two contained preservative without giving the required declaration. The meat content ranged from 50·0 per cent. to 99·6 per cent. the average being 65·6 per cent.

Other Meat Products. A tin of beef steak with gravy was substandard in meat content. A meat pie contained only 19 per cent. of meat, whereas the minimum for this size of pie was 25 per cent. One meat and potato pie was condemned because it was mouldy.

Soft Drinks. Shandy is prepared from soft drink with a 'dash' of beer. The beer content of shandies sold on licensed premises varies greatly at the discretion of the bar-tender, and may be quite high; but when sold as a bottled soft drink, shandy must not contain more than 2 per cent. of proof spirit. That is the legal maximum alcohol content, but as yet there is no legal minimum, and some soft drinks manufacturers have been adding so little beer that the product was not worthy of the name. After considerable research, public analysts recommended a lower limit of 1·5 per cent. proof spirit. Out of 22 samples, only two were below the limit, with 0·95 and 1·05 per cent. proof spirit.

Four soft drinks failed to comply with the Soft Drinks Regulations as regards fruit juice content, saccharin, etc. One was deficient in Vitamin C, and several bore labels which did not comply with the Regulations as regards size and colour of lettering.

Brandy. Only one sample was below standard; instead of the declared 70° proof, this was only 67° proof.

Preserves. A 'home made' orange marmalade was low in soluble solids owing to insufficient sugar, or inadequate boiling. A jar of strawberry jam had a faulty lid; the contents were covered with a thick layer of mould.

Rum Truffles. These contained no rum, and in fact they did not even taste of rum.

Confectionery. A walnut cake had a fishy taint; it may have been cut with a knife previously used for fish, or been stored near to fish.

Two samples of cream confectionery which should have contained real cream, were filled with artificial cream.

Drugs. Two samples of epsom salts contained excessive amounts of iron, and two samples of zinc oxide plaster were also substandard.

Prohibited Food Colours. All relevant samples were tested for food colouring; only one, red cherries in syrup, contained a prohibited dye.

IRREGULAR LABELS:

Out of the hundreds of labels scrutinised for compliance with the Labelling of Food Order, 1953, 21 were irregular. The offences included failure to declare the presence of artificial sweeteners in soft drinks, and the form, size and colouring of the lettering. One sample of orange drink was misdescribed as orange juice.

General claims for the presence of vitamins and minerals must not be made; they must be declared specifically and in quantities per ounce. One sample of rice was criticised because of a general declaration of minerals and vitamins.

Several samples were irregular because the lists of ingredients were stated in the wrong order.

Two cans of processed peas were entirely without label; the tins appeared to have been salvaged.

First-aid dressings were unsatisfactory in that labels did not supply the information required by the British Pharmaceutical Codex, and several drugs were given the suffix 'B.P.' whereas it should have been 'B.P.C.'

MOULDY FOOD:

A sample of prepared dough contained mouldy particles, and two large bottles of gooseberries were condemned as unfit for human consumption; the lids were leaky and the contents were covered with mould.

FOREIGN BODIES IN FOOD:

These are generally brought in following complaints by the public.

There was a piece of dirty cloth amongst currants, a piece of thick wire in nut crackle, and a large piece of broken glass in a strawberry mousse.

There were three complaints about loaves of bread; one contained a moth, another, part of a multiwall paper container, and a third contained a black beetle.

Two milk bottles had been inadequately cleansed; one contained a deposit of vegetable debris and dust, the other contained a film of dried milk solids.

A metal screw was discovered in a bar of chocolate; it was badly damaged by its passage through machinery.

KEIGHLEY EXCEPTED DISTRICT

V. P. McDonagh, Borough School Medical Officer

This report is compiled in accordance with the arrangements made by the County Council of the West Riding of Yorkshire as to the School Health Service in the Borough of Keighley and details the work carried out during the year under review.

The report follows the usual pattern. The investigations of the psychologists into various reading and academic abilities of the children are of great interest, although there is no evidence from the past with which to compare them. They indicate, however, that much further investigation needs to be made into the causes of academic failure in children of average intelligence and into special teaching methods. This strictly may seem to have very little to do with a school health report but it is within our knowledge that children who are not properly placed academically tend to become maladjusted or delinquent or develop neurotic symptoms of one kind or another. The fulfilment of a child's intellectual ability is a positive contribution towards his mental health and it would, therefore, seem to be important that these investigations should continue.

The Medical Inspection of School Children:

The number of pupils on the registers at the end of the year is shown below together with the figures for the previous year:

	1969	1968
Nursery	43	43
Primary	5,603	5,500
Middle Schools (including Secondary Technical)	1,910	1,892
Voluntary Secondary	552	527
Upper Schools	1,529	1,489
Special Schools	96	95

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils who received a full medical examination together with classification of the physical condition of the pupils inspected, the number of pupils found not to warrant a medical examination in connection with the selective medical examinations and the number of pupils found to require treatment (excluding dental disease and infestation with vermin).

Age groups inspected (by year of birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory		For defective vision (excluding squint)	For any other condition recorded in Table III	Total individual pupils
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1965 and later	104	104	—	—	—	13	13
1964	566	566	—	—	2	143	144
1963	258	258	—	—	1	91	91
1962	76	76	—	—	—	19	19
1961	237	237	—	426	8	77	84
1960	52	52	—	39	—	12	12
1959	—	—	—	—	—	—	—
1958	—	—	—	—	—	—	—
1957	—	—	—	—	—	—	—
1956	—	—	—	—	—	—	—
1955	—	—	—	78	—	—	—
1954 and earlier	—	—	—	620	—	—	4
TOTAL	1293	1293	—	1163	11	355	363

Column (3) total as a percentage of Column (2) total ... 100.00
 Column (4) total as a percentage of Column (2) total ... 0.00

B. Other Inspections

Number of Special Inspections	...	1,911
Number of Re-Inspections	...	930
		<hr/>
Total	...	2,841
		<hr/>

Comparative Table of Inspections carried out:

<i>Year</i>	<i>Routine</i>	<i>Specials</i>	<i>Re-Inspections</i>
1969	1,293	1,911	930
1968	1,313	1,963	1,074
1967	1,354	1,629	1,033
1966	1,805	1,918	834
1965	2,038	3,053	1,185

SELECTIVE SCHEME:

The selective scheme of medical examination of pupils in the intermediate age group has continued as described in previous reports. During the year 754 questionnaires were distributed of which 693 were returned and 289 of these pupils were invited to attend for a medical examination. Details of the defects found are shown in Table III.

School leaving examination of pupils during their last year of compulsory school attendance:

The selective scheme of examination of school leavers was continued in 1969 following the instigation of this procedure in 1967. Questionnaires were distributed to parents of school leavers for completion and return. These were scrutinised together with all the available medical records. At the medical interviews, which were held in the schools, pupils were selected for a full medical examination, to be carried out at the school clinic by appointment.

Six hundred and ninety-eight pupils were interviewed in accordance with the provisions of this scheme. In no case however, was it found necessary to invite a pupil to attend the school clinic for a fuller medical examination.

CONSULTING SESSIONS:

Consulting sessions are held twice weekly at the school clinic by a departmental medical officer. Appointments are given to parents, following school medical inspections, to bring their children to the school clinic for investigation and consultation if this is requested by the parents or advised by the departmental

medical officer who has carried out the medical inspections in school. Pupils are also referred to these clinics by teachers, education welfare officers or are brought by the parents themselves for examination and consultation for a variety of health problems.

The poor school attender is referred frequently for the problem to be assessed and for decisions to be made regarding treatment, the need for special educational placement or for reassurance that a child is fit to attend school regularly.

Parents who are concerned about their child's general health, behaviour difficulties or disorders such as nocturnal enuresis frequently seek the advice of the departmental medical officer. If further investigation is considered to be necessary referral is made appropriately either to the family doctor, to a specialist, or to the child guidance clinic. Pupils attend the clinic for advice concerning ear, nose and throat conditions, chest, orthopaedic and skin conditions.

This consulting service is also available to pre-school children. The health visitors/school nurses who are not satisfied with the progress of the children attending the child welfare centres refer them to the departmental medical officer at the school clinic for a development diagnosis and advice. They refer too for an opinion for more specific conditions particularly orthopaedic, visual defects or disorders of speech development.

Every opportunity is taken at these sessions to promote health education within a doctor-patient relationship.

TABLE II
INFESTATION WITH VERMIN

(a)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	...	...	...	19,673
(b)	Total number of individual pupils found to be infested...	...	...	...	661
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	...	...	...	—
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	...	...	...	—

TABLE III
DEFECTS FOUND BY PERIODIC AND SPECIAL MEDICAL INSPECTIONS
DURING THE YEAR

NOTE.

All defects, including defects of pupils at Nursery and Special Schools, noted at periodic and special inspections are included in the following table, whether or not they were under treatment or observation at the time of inspection.

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS								SPECIAL INSPECTIONS	
		ENTRANTS		LEAVERS		OTHERS		TOTAL		(T)	(O)
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)		
4	Skin	10	1	—	—	5	1	15	2	231	5
5	Eyes— <i>a.</i> Vision ...	3	1	—	—	8	1	11	2	41	3
	<i>b.</i> Squint ...	36	—	—	—	11	1	47	1	50	—
	<i>c.</i> Other ...	1	—	—	—	2	—	3	—	14	—
6	Ears— <i>a.</i> Hearing ...	35	2	—	—	20	7	55	9	156	33
	<i>b.</i> Otitis Media	3	1	—	—	—	—	3	1	16	—
	<i>c.</i> Other ...	6	1	—	—	2	—	8	1	36	—
7	Nose and Throat ...	51	16	—	—	9	5	60	21	75	5
8	Speech	46	5	—	—	11	1	57	6	122	12
9	Lymphatic Glands ...	—	1	—	—	—	—	—	1	2	—
10	Heart... ..	2	2	—	—	—	3	2	5	2	21
11	Lungs	11	5	—	—	11	6	22	11	86	14
12	Developmental—										
	<i>a.</i> Hernia ...	2	—	—	—	—	—	2	—	—	—
	<i>b.</i> Other ...	2	1	—	—	1	—	3	1	4	1
13	Orthopædic—										
	<i>a.</i> Posture ...	—	—	—	—	—	—	—	—	3	—
	<i>b.</i> Feet ...	22	—	—	—	1	1	23	1	47	2
	<i>c.</i> Other ...	16	—	—	—	2	—	18	—	43	1
14	Nervous System—										
	<i>a.</i> Epilepsy ...	5	—	—	—	1	1	6	1	26	8
	<i>b.</i> Other ...	3	2	—	—	—	—	3	2	5	1
15	Psychological—										
	<i>a.</i> Development	13	5	—	—	16	13	29	18	294	65
	<i>b.</i> Stability ...	12	6	—	—	16	12	28	18	261	57
16	Abdomen	3	—	—	—	1	—	4	—	16	1
17	Other... ..	50	3	—	—	17	4	67	7	43	8
18	Totals	332	52	—	—	134	56	466	108	1,573	237

T = Pupils found to require treatment

O = Pupils found to require observation

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:

- (i) cases treated or under treatment during the year by members of the Authority's own staff;
- (ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board; and
- (iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

A. Eye Diseases. Defective Vision and Squint:

	Number of cases known to have been dealt with	
	1969	1968
External and other, excluding errors of refraction and squint ...	45	49
Errors of refraction (including squint)	440	487
Total	485	536
Number of pupils for whom spectacles were prescribed	206	286

The figures in respect of the year 1969 relate to the work undertaken at the ophthalmic clinic up to 13th August, 1969, from which date due to circumstances outside our control the services of a consultant ophthalmologist were not available.

SCREENING TESTS OF VISION:

Routine tests of visual acuity were carried out by the assistant health visitors/school nurses in the age groups as follows: 6-7 years, 10-11 years, 12-13 years, 14-15 years. Towards the end of 1969 a vision screening test was also carried out for each pupil at the school entrant medical examination. Formerly tests of colour vision were only made in the age group 12-13 years but towards the end of the year colour vision was also tested in the age group 10-11 years. The conduct of vision screening in school has been greatly facilitated by the use of the Keystone vision screening apparatus which was first used in the Autumn term.

Pupils found to be suffering from defective vision were referred direct to the ophthalmic clinic by the assistant health visitors/school nurses, subject to parental consent and unless the parents chose to arrange for an examination through their general practitioner.

Since the resignation of the consultant ophthalmologist pupils have been referred to their family doctors so that arrangements could be made for an ophthalmic examination. It is hoped that the normal school ophthalmic service will soon be restored.

General:

During the year 45 cases suffering from conditions of the eyes such as blepharitis and conjunctivitis were treated at the minor ailments clinic. Four hundred and fourteen cases of defective vision and 26 cases of squint were examined by the consultant ophthalmologist.

Following examination it was found that in 77 cases the provision of spectacles was not thought to be necessary, in 164 cases existing spectacles were considered to be satisfactory and 26 cases were referred to the Bradford Eye and Ear Hospital.

The consultant ophthalmologist attended two sessions per week until he resigned.

The number of repairs to and replacements of spectacles amounted to 182.

B. Diseases and Defects of Ear, Nose and Throat:

							Number of cases known to have been dealt with	
							1969	1968
Received operative treatment:								
(a)	for diseases of the ear	...	...	...	...	...	—	—
(b)	for adenoids and chronic tonsillitis	...	...	...	...	...	—	—
(c)	for other nose and throat conditions	...	...	...	...	...	—	—
Received other forms of treatment							83	66
Total							83	66
Total number of pupils still on the register of schools at 31st December, 1969 known to have been provided with hearing aids:								
(a)	during year 1969	...	...	...	...	...	2	
(b)	in previous years	...	...	...	...	...	5	

SCREENING TESTS OF HEARING:

The audiometric survey of seven year old pupils was continued during the year, together with the examination of pupils in the ‘ at risk ’ categories.

Following the audiometric sweep test of pupils in school a weekly clinic is held where pupils who fail the test are seen by appointment for the purpose of obtaining an audiogram and medical history. A further weekly clinic is held

when a departmental medical officer is available to conduct an aural examination and select cases for referral to the consultant otologist. The family doctors are informed in the usual way or cases are referred to them in the instances where this is desired. There is good communication between the departmental medical officers, family doctors and consultant otologist.

Referral to the child guidance clinic is easily effected so that advice re educational requirements or emotional problems associated with hearing loss is readily available.

Twenty-nine pupils in attendance at Keighley schools are suffering from a bilateral hearing loss of 30 decibels or more. Hearing aids have been prescribed for seven of these pupils.

All pupils suffering from bilateral hearing loss of 30 decibels or more in attendance at the ordinary school have had a psychological examination during the year. Fuller details are given in the section of the report on child guidance treatment which emphasises the need for the services of a specialist teacher of the deaf to advise teachers in the ordinary schools in the education of children suffering from defects of hearing.

Pupils Tested by Pure-Tone Audiometry

	Number Tested	No appreciable hearing loss	Referral for investi- gation	Already attending Otologist
'At risk' categories				
(i) deafness in the family ...	6	1	5	—
(ii) prenatal causes:				
maternal rubella	—	—	—	—
other conditions	—	—	—	—
(iii) perinatal causes <i>e.g.</i> toxæmia, anoxia, kernicterus, rhesus incompatability, prematur- ity, etc.	—	—	—	—
(iv) postnatal:				
congenital defects	2	2	—	—
cerebral palsy	—	—	—	—
middle ear disease	33	14	16	3
meningitis or encephalitis	1	1	—	—
speech retardation or defect	29	26	3	—
educational retardation ...	34	33	—	1
Routine test on children in 6/7 year age group	993	974	19	—
Referred for possible hearing loss...	82	66	15	1
	1,180	1,117	58	5

C. Orthopædic and Postural Defects:

				Number of cases known to have been dealt with	
				1969	1968
(a)	Pupils treated at clinics or out-patient departments	...		119	279
(b)	Pupils treated at school for postural defects	...	...	—	—
	Total	...		119	279

Mr. Skinner, Physiotherapist reports:

“The past year has seen no marked changes in the structure of the services provided.

Apart from remedial exercise treatments, we have assisted in the work of the child guidance clinic, provided ultra-violet ray treatment for specific skin disorders, and the debilitated, and supervised the work at the swimming baths for physically and emotionally handicapped children. In addition we have also assisted at the weekly swimming class held at Whinburn Residential Special School.

The monthly orthopædic clinic has continued under Dr. McNae’s supervision to advise treatment for those requiring it.”

The following shows details of the work undertaken by the physiotherapist.

School Children							No. of Cases	Attendances
Asthma	...	...	...	...	...	...	4	24
Benign Hypotonia	...	...	...	...	...	...	1	4
Breathing	...	...	...	...	...	...	45	805
Cerebral palsy (spastic)	...	...	...	...	...	...	6	43
Cerebral palsy (other)	...	...	...	...	...	...	10	219
Curly toes	...	...	...	...	...	...	10	121
Foot exercises	...	...	...	...	...	...	31	378
Muscular dystrophy	...	...	...	...	...	...	3	80
Posture	...	...	...	...	...	...	1	10
Remedial exercises	...	...	...	...	...	...	3	72
Round shoulders	...	...	...	...	...	...	3	24
Scoliosis	...	...	...	...	...	...	1	8
Spina bifida	...	...	...	...	...	...	1	10
Pre-school Children								
Cerebral palsy	...	...	...	...	...	...	7	134
Curly toes	...	...	...	...	...	...	2	31
Foot exercises	...	...	...	...	...	...	5	70
Remedial exercises	...	...	...	...	...	...	1	39
Round shoulders	...	...	...	...	...	...	1	3

Consultant Orthopædic Clinic:

Number of sessions held	...	...	...	...	...	...	12	
								Pre-school Children School Children
Number of individual patients seen by consultant, including those continuing attendance from previous year	...						34	95
Number of above—								
(a) referred for operative treatment as short-stay cases only	...	...	...	...	...	...	—	—
(b) recommended long-stay hospital school	...	...					—	—
(c) recommended treatment by orthopædic nurse or physiotherapist—								
(i) at treatment centres	...	...	...	...			1	12
(ii) domiciliary	...	...	...	...	...		—	—
Number of children who obtained operative treatment during the year	...	...	...	...	...	...	—	1
Total number of attendances at consultant clinic	...	...					38	109

Treatment Centres:

Number of sessions held	...	...	...	...	...	428	
Total number of patients treated (including cases continuing treatment from previous year)	...	...	...	...	...	16	119
Total number of attendances	...	...	...	...	...	277	1,798

Domiciliary Treatment:

Total number treated	...	...	...	...	...	...	—	—
Total number of visits to patients' homes	...	...	...	...	...	...	—	—

Appliances:

Number of appliances—(a) recommended	...	...	...	...	...	—	—
(b) obtained	...	...	...	...	...	—	—

D. Diseases of the Skin (excluding uncleanliness for which see Table II):

								Number of cases known to have been treated	
								1969	1968
Ringworm—(a) Scalp	...	...	...	...	...	...	...	—	—
(b) Body	...	...	...	...	...	...	...	—	2
Scabies	...	...	...	...	...	...	...	227	145
Impetigo	...	...	...	...	...	...	...	91	56
Other skin diseases	...	...	...	...	...	...	...	212	196
Total								530	399

It will be seen from the figures that the incidence of scabies has increased during the year. The affected children have been treated at the school clinic, child contacts have also received treatment at the clinic and their homes visited

by the health visitors/school nurses. Adult contacts have been advised and provided with a supply of Benzyl Benzoate for their own treatment. School inspections have been carried out but there has been little evidence of any spread of infection within the schools. Infection has occurred mostly in the homes and between relatives and neighbours. The incidence of impetigo which has also increased has occurred largely as a secondary complication of other skin diseases.

A weekly clinic is held for the treatment of plantar warts.

E. Child Guidance Treatment:

	Number of cases known to have been treated	
	1969	1968
Pupils treated at Child Guidance Clinics	213	178

Location of clinic:

School Clinic,
147, Skipton Road,
Keighley.

Number of sessions held during the year	182		
	Boys	Girls	Total
Number of new cases seen... ..	65	43	108
Number of cases referred from previous year	69	36	105
Total number of cases discharged or admitted for residen- tial treatment	71	35	106
Number of cases carried forward... ..	63	44	107

The staff of the child guidance clinic in 1969 remained the same as in the previous four years with the addition of a second psychologist. The full team consisted of a physician in charge, who is a senior departmental medical officer, two psychologists and a psychiatric social worker with the assistance of a mental welfare officer.

With the increase in staff it was possible to see a larger number of cases at the clinic but this number is necessarily limited due to the time which needs to be spent by the physician and psychiatric social worker in psychotherapy, home visiting and the counselling of parents. The extra services of the psychologists have been largely employed in more frequent school visiting and in conducting more intensive psychological investigations in the schools. In this way the work of the child guidance team has branched out from the clinic into the schools.

The tendency for younger school children and pre-school children to be referred to the clinic for examination has continued, these referrals largely being made by the family doctors and health visitors. As in previous years physically handicapped children have been examined at the child guidance clinic, the necessary investigations arranged, parents counselled and appropriate recommendations made to the local education authority. Other cases seen have

included the usual ones of children suffering from habit, nervous and behaviour disorders. Educational problems have occupied much of the attention of the team and have often been associated with secondary emotional disturbance.

During the year one boy was admitted to a hostel for maladjusted pupils but later was withdrawn by his parents. Another boy of middle school age was admitted to a residential school for delicate pupils where he is making good progress. In December a pre-school girl was admitted to the Kanner Unit at High Royds Hospital for observation as an autistic child.

As a result of the increase of staff it was possible for the psychologists to conduct special investigations in the schools and it is anticipated that this work will continue. Arrangements were made for partially hearing pupils on the register to receive a psychological examination, the results of which follow this section of the report.

In response to a request from the headmaster of one of the two grammar schools investigations were carried out with the backward readers who had transferred from the middle schools at the age of fourteen years. The psychologist's report is given below. Certain other pupils in middle schools who had previously been reported as being in need of special education in the ordinary school were re-examined to ascertain their progress.

The figures below relate to the pupils who remain in attendance at school and who are still considered to be in need of special education in the ordinary school. It will be seen by these figures and by the evidence of educationally retarded children received into the grammar school at fourteen years of age that many pupils need special educational help, and need it at an early age so that they can benefit fully from the education provided in the grammar schools. A remedial centre for pupils of primary school age is once again strongly recommended.

Mrs. Castle, Educational Psychologist reports:

“A psychological survey of pupils with partial hearing within the ordinary and special schools was carried out. Each pupil was administered an Intelligence Test, either the Wechsler Intelligence Scale for Children or the Terman Merrill (Form L-M) and the Burt (Rearranged) Reading test in order to obtain both an intelligence and reading quotient. All testing was done within the school.

Since pupils who possess only partial hearing are likely to be at a disadvantage in a school not designed to cope with this particular disability, special attention was paid to any significant discrepancies between reading attainments as measured by the Burt Test and the child's ability as suggested by the Intelligence Test result. In the case of children administered the W.I.S.C. Test further comparisons could be made between the Verbal Scale result (which reflects verbal and scholastic attainments) and the Performance Scale results, success at which does not rely on any degree of verbal skill.

Results.

Breakdown of children seen into sex and type of school attended.

	Infant	Junior	Secondary	Special School	Total
Boys	2	8	6	2	18
Girls	2	4	—	1	7
Total... ..	4	12	6	3	25

The ratio of boys to girls seen is over 2:1.

Comparison between mean W.I.S.C. I.Q. results and mean Reading Quotient.

No.	W.I.S.C.			Burt Reading Quotient
	X Verbal I.Q.	X Perf. I.Q.	X Full Scale I.Q.	
Boys 15	83·4	92·6	89·3	76·5
Girls 6	81·9	97·8	87·7	77·5
Total 21	82·9	94·1	88·6	76·8

Comparison between mean Terman-Merrill (Form L-M) I.Q. and mean Reading Quotient.

No.			X Terman Merrill I.Q.	X Burt Reading Quotient
Boys	...	3	95·3	87·0
Girls	...	1	108·0	89·0
Total	...	4	98·5	87·5

Significance of the difference between the means of the W.I.S.C. Full Scale I.Q. and mean R.Q.

		No.	Diff between × F/Scale I.Q. + × R.Q.	Level of significance
Boys	...	15	12·8	1%
Girls	...	6	10·2	Not significant
Total	...	21	11·8	1%

Significance of the difference between the mean of the Terman-Merrill I.Q. and mean R.Q.

	No.	Diff. between × T.M. I.Q. + × R.Q.	Level of significance
Boys ...	3	8.3	Not significant
Girls ...	1	19.0	Not significant
Total ...	4	11.0	5%

Significance of the difference between the means of the Verbal and Performance Scale I.Q.

	No.	Diff. between × Verbal I.Q. + × Perf. I.Q.	Level of significance
Boys ...	3	8.3	Not significant
Girls ...	1	19.0	Not significant
Total ...	4	11.0	5%

As the total number of children involved in this survey was small, care must be taken in drawing any general conclusions. However, the statistical analysis of the results indicates that:

(1) Taking the total number of pupils involved there is a significant difference between the I.Q. result and reading quotient, indicating a general degree of underattainment in reading.

(2) Again taking the total, there is a significant difference between the means of the Verbal and Performance Scale I.Q.'s indicating that as a whole the group is underfunctioning in regard to verbal skill and scholastic attainments in relation to suggested ability.

(3) If the criterion of a serious degree of reading underattainment is taken as a discrepancy of 15 points difference or more between I.Q. and R.Q. 10 such cases are to be found in this group out of 25 pupils.

Twenty-five pupils with partial hearing were psychologically examined in school. Analysis of the results indicates that these children, taken as a whole, are behind in reading attainment and are tending to do poorly in academic work."

Mr. Mannix, Educational Psychologist reports:

“ During 1969 it was decided to start routine re-assessments at Braithwaite Day Special School on the lines already established at the County’s residential schools. This usually involved the testing of children of 11 or 12 years of age whose general progress was thought by the headmaster to be particularly good or particularly poor, although children were also referred for other reasons.

Eight Braithwaite children were seen during the year:

	Age	Boys	Girls
Thought capable of benefiting from transfer to the ordinary school	10 to 13 yrs.	4	1
Thought to need transfer to training centre	7 and 10 yrs.	2	—
Decision needed re employment	15+	1	—
		7	1

Each case involved both formal testing and discussion with head and class teachers.

A start was also made with regular visits to the junior wing of the training centre with a view to reassessment when necessary. It is thought that the psychologist could provide a good deal of useful information when a child first attends the centre. A method of recording progress has been suggested.

Five visits were made to the training centre and four children, all boys, were formally assessed.

Reading retardation continues to be a prime concern of the psychologists. Poor readers are discovered among child guidance patients or are referred to the departmental medical officers by head teachers as failing to make general progress in school.

Particulars of children who, though failing to make adequate scholastic progress are recommended for special education in ordinary schools, are kept by the psychologists. As and when opportunity allows, their progress in reading and spelling is watched.

Nine pupils, all boys, at middle schools were seen during the year for this purpose.

A discrepancy of up to 5 points between I.Q. and R.Q. was disregarded. A discrepancy of 15 points or more was thought to indicate serious retardation in reading. Using these criteria, test result shows:

Not now retarded	...	...	3
Slight retardation	...	...	1
Still severely retarded	...	...	5

However, these results are based on reading vocabulary tests. In all cases the quotient for reading comprehension was lower than for 'mechanical' reading and (in all except one) the spelling quotient was even lower. Only one spelling quotient was above 64.

A small survey of reading retardation was undertaken at Greenhead Grammar School during the year. Schonell Reading Tests were given by the school staff and by this means 10 boys and 6 girls were selected whose reading ages were 2 years or more below their actual ages. Ages ranged from $14\frac{1}{2}$ to $15\frac{1}{2}$ years.

Detailed individual assessments were not possible in the time available and only a rough screening for ability was given. Tests used were Raven's Progressive Matrices, Sets A to E and the Terman Merrill Vocabulary Test. Results are shown below.

Ten pupils were below average in one or other of these tests, including 6 who were below average in both. Their reading was retarded on average, by 3 years 7 months.

The 6 who are average or above average in both tests are as badly retarded in reading as the others (3 years 10 months).

Other points arising from this sample of older poor readers were:

- (1) All the sample are 'voluntary transfers' from middle (former secondary) schools. They seem to amount to 14 per cent. of the boys and 9 per cent. of the girls transferred in that year.
- (2) There is no record of any of these children having been referred to the departmental medical officer for lack of progress.
- (3) Three of the pupils were known to have defects of sight or hearing but these were not regarded as serious.
- (4) Six other children had a medical history which might have influenced their attainments—speech defect, enuresis and frequent colds and bronchitis.

It is, of course, not possible to generalise from these small samples.

Greenhead Grammar School
Retarded Readers—Test Categories

	Non-Verbal Ability (Matrices Test)				Total
	Superior	Above Average	Average	Below Average	
Verbal Ability Good Average	0	2	0	1	3
Average	1	0	3	1	5
Below Average	0	0	2	6	8
Total	1	2	5	8	16

Double lines indicate the lower boundary of average performance.

Special Education in the Ordinary School.

No. of new cases examined by a departmental medical officer and/or psychologist during 1969 and considered as being in need of special education	...	...	...	...	...	...	...	18
No. of cases examined and considered to be in need of special education in previous years and still in attendance at school	...	...	...	...	...	...	...	102
Total number of children who have been examined and are considered to be in need of special education in the ordinary school	...	...	...	...	...	...	...	120"

F. *Speech Therapy:*

	Number of cases known to have been treated	
	1969	1968
	Pupils treated by speech therapists 171	67

Speech therapy during the year was carried out by the speech therapist employed by the Authority for four sessions per week until September, 1969, when it became possible to extend the service. An agreement was entered into between the Authority and the Hospital Management Committee whereby the services of the hospital speech therapist were made available for three sessions per week at the School Clinic commencing 30th September. Thereafter the speech therapy service was available for seven sessions per week.

Mrs. Hornsby Smith, Speech Therapist reports:

“Therapy has continued at Whinburn and Braithwaite E.S.N. Schools alternate Thursday afternoons.

Since the acquisition of a second therapist the waiting list has been greatly reduced, and it is now possible to attend the Keighley Training Centre every 4 or 5 weeks.”

G. Other Treatment Given:

						Number of cases known to have been treated	
						1969	1968
(a)	Pupils with minor ailments	...	...	...	...	553	510
(b)	Pupils who received convalescent treatment under School Health Service arrangements	...	...	...	...	—	—
(c)	Pupils who received B.C.G. vaccination	...	...	...	...	859	276
(d)	Other than (a), (b) and (c) above—Ultra Violet Light	...	...	...	...	13	9
Total						1,425	795

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

The tuberculin testing of school entrants was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken under the provisions of this scheme:

Number invited	...	...	...	...	...	1,018
Refused	...	...	...	...	...	79
Absent	...	...	...	...	...	152
Previously examined	...	...	...	...	...	28
Negative	...	...	...	...	...	751
Positive	...	...	...	...	...	8

Of the eight cases found to be positive, six had previously been vaccinated with B.C.G. and the remaining children were referred to the chest physician for further investigation and/or observation.

B.C.G. VACCINATION OF OLDER SCHOOL CHILDREN:

The scheme for the vaccination against tuberculosis of older school children was continued during the year, details of which are set out below:

Number of Medical Officers approved to undertake B.C.G. Vaccination	3
Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously	1,603
Number found to have been vaccinated previously	51
Number of acceptances	945
Percentage of acceptances	60.89
Pre-vaccination Tuberculin Test—	
Number of children tested	929
Result of Heaf Test:	
(i) Positive 68, (ii) Negative 859, (iii) Not ascertained 2	929
Percentage positive	7.34
Vaccination—	
Number vaccinated	859

Included in the above figures are 83 immigrant children who were tuberculin tested as part of a full medical examination which was undertaken prior to their admission to school.

Ultra Violet Light:

Thirteen pupils received ultra violet light treatment of whom three were continuing at the end of the year. Through the inter-availability of clinics, three pre-school children also received ultra violet light treatment, two of whom had been discharged at the end of the year. Altogether 91 sessions were held at which 294 attendances were made by pupils and 39 by the pre-school children.

Patients are normally referred by their general practitioners.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:

TABLE V

	New Ascert-ainments	Re-Ascertainments	New placings in Special Schools	Total No. attending Special Schools		Number awaiting placement in Special Schools	Number receiving home tuition
				Day	Boar- ding		
Blind	1	—	—	—	—	1	—
Partially Sighted	1	—	—	1	1	1	—
Deaf	—	—	—	—	3	—	—
Partially Deaf	—	—	—	4	2	—	—
Educationally Subnormal	12	—	10	96	5	—	—
Epileptic	—	—	—	1	—	—	—
Maladjusted	—	—	—	—	2	—	—
Physically Handicapped	1	—	3	4	5	1	—
Suffering from Speech Defect	—	—	—	—	—	—	—
Delicate	4	—	3	—	4	—	1
Total	19	—	16	106	22	3	1

BRAITHWAITE DAY SPECIAL SCHOOL:

At the end of the year 96 pupils were attending the Braithwaite Day Special School. Of these 53 were Keighley pupils, the remainder were admitted from areas situated outside the Borough.

Keighley pupils are now admitted at an earlier age than formerly and only occasionally are pupils admitted who are more than seven years of age.

MENTALLY SUBNORMAL CHILDREN:

No child was reported during the year as being "unsuitable for education in school" in accordance with Section 57(4) of the Education Act, 1944 as amended; five children were admitted to a day training centre on a voluntary basis and six were reported as requiring 'care and guidance' on leaving school.

Nocturnal Enuresis:

During the year 21 pupils suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan and of these four were still under treatment at the end of the year.

Health Education:

Our activities during the current year were extended to include two more schools, one of which is the day special school for educationally subnormal pupils. The main subjects covered in our general courses are personal hygiene, smoking, menstruation, home safety, drugs, food hygiene etc. The courses follow a standard pattern of an introductory talk then either a sound film, a filmstrip or a tape recording. Discussion and questions from the children follow. In one instance a course of first aid was given in a school and was followed by visits to the abattoir and sewage works. Lectures were also given by health visitors in connection with the Duke of Edinburgh Award on both first aid and personal hygiene to groups of boys and girls.

Medical Examination of Entrants to Training Colleges:

Ninety-two students were medically examined during the year in connection with their applications for entry to Training Colleges compared with 72 in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

Forty-five children were examined by departmental medical officers during the year to determine their fitness for employment under the Authority's bye-laws relating to the employment of children as compared with 30 in 1968. The above figures include those children taking part in entertainments. No child was found to be unfit.

Dental Inspection and Treatment:

Mr. Midgley, Area Dental Officer reports:

“The past year has seen little change in the pattern of dental decay, and differs very little from that for the previous year. Very few children now at school can be found who have not had some form of dental treatment, and gross dental neglect is now the exception. The six monthly recall system for selected patients known to be exceptionally prone to decay has been further extended and is greatly appreciated by those parents concerned.

Liaison with two more practitioners in the General Dental Service has been established whereby their orthodontic cases are now referred to the clinic for this specialised treatment.

Part-time assistance was available for the greater part of the year.

One further improvement has been effected by arranging for the dental specialist to treat children requiring crowns and bridges at Keighley instead of Skipton.”

TABLE VI

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	819	939	208	1,966
Subsequent visits	487	2,072	406	2,965
Total visits	1,306	3,011	614	4,931
Additional courses of treatment commenced	51	86	32	169
Fillings in permanent teeth... ..	760	2,185	685	3,630
Fillings in deciduous teeth	340	16	—	356
Permanent teeth filled	710	2,121	681	3,512
Deciduous teeth filled	318	16	—	334
Permanent teeth extracted	85	494	109	688
Deciduous teeth extracted	1,349	364	—	1,713
General anæsthetics... ..	462	357	47	866
Emergencies	195	83	14	292
Number of pupils X-rayed				133
Prophylaxis				113
Teeth otherwise conserved				13
Number of teeth root filled				16
Inlays				11
Crowns				8
Courses of treatment completed... ..				1,948

Orthodontics

Cases remaining from previous year ...	51
New cases commenced during year ...	46
Cases completed during year	34
Cases discontinued during year	6
Number of removable appliances fitted...	83
Number of fixed appliances fitted ...	1
Pupils referred to Hospital Consultant ...	—

Prosthetics

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	—	—	1	1
Pupils supplied with other dentures (first time)...	—	15	7	22
Number of dentures supplied	—	36	19	55

Anæsthetics	General Anæsthetics administered by Dental Officers...	15
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Inspections

(a)	First inspection at school. Number of pupils	7,620
(b)	First inspection at clinic. Number of pupils	783
	Number of (a) + (b) found to require treatment	...	...	...	...	...	3,603
	Number of (a) + (b) offered treatment	...	...	...	...	...	3,410
(c)	Pupils re-inspected at school or clinic	...	...	...	...	...	640
	Number of (c) found to require treatment	...	...	...	...	..	369

Sessions

Sessions devoted to treatment	512*
Sessions devoted to inspection	...	...	...	47
Sessions devoted to Dental Health Education...				1

* Includes 1 anæsthetic session

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1969

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.SC., D.P.H.
Deputy County Medical Officer	H. W. S. Francis, M.A., M.B., B.CHIR., D.P.H.
Principal Medical Officer:	
Care of Mothers and Young	
Children and Nursing Services	D. E. Robertshaw, M.B., CH.B., D.P.H., D.C.H.
Mental Health Service	... D. E. Jeremiah, M.B., B.S., D.T.M. and H., D.P.H.
School Health Service	... C. S. Smith, M.B., B.S., M.R.C.S., L.R.C.P.
Epidemiology	... G. E. Leyshon, M.B., CH.B., D.OBST.R.C.O.G., D.P.H.
Additional Medical Officer	... J. A. Cooney, M.B., CH.B., B.A.O., D.T.M. and H.
Venereologist (part-time)	... J. A. Burgess, M.D., CH.B., D.P.H.
Obstetrician (Joint appointment with Hospital Services)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST.R.C.O.G.
Medical Officer for the Child Guidance Service	... Katherine N. Maxwell, M.B., CH.B.

Divisional Medical Officers—

Division No. and Name

1 (Skipton)	... M. Hunter, M.B.E., M.D., CH.B., D.P.H.
3 (Keighley)	... V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley)	... J. Battersby, M.B., CH.B., D.P.H.
5 (Horsforth)	... A. Telford Burn, M.B., B.S., D.P.H.
7 (Harrogate)	... N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Rothwell/Wetherby)	W. D. Dolton, M.A., M.B., B.CHIR., M.R.C.S., L.R.C.P., D.P.H.
10 (Goole)	... S. K. Appleton, M.D., CH.B., D.P.H., D.T.M.
11 (Castleford)	... J. M. Paterson, M.B., CH.B., D.P.H.
12 (Pontefract)	... J. F. Fraser, M.B., B.S., D.P.H., D.OBST.R.C.O.G.
13 (Morley)	... G. Ireland, B.SC., M.B., B.CH., D.P.H.
15 (Spenborough)	... W. M. Douglas, M.B., CH.B., D.P.H.
18 (Calder Valley)	... N. E. Gordon, M.B., CH.B., D.P.H.
20 (Colne Valley)	... P. M. Sammon, M.B., CH.B., D.P.H.
22 (Wortley)	... F. C. Armstrong, M.B., B.CH., D.P.H.
23 (Hemsworth)	... J. S. Walters, M.C., M.B., CH.B., D.P.H.
25 (Barnsley)	... C. G. Oddy, M.B., CH.B., D.P.H.
26 (Wath upon Dearne)	D. J. Cusiter, M.B., CH.B., D.P.H., D.T.M. and H.

Divisional Medical Officers—continued

27 (Doncaster) ...	...	R. Stalker, M.B., CH.B., D.P.H.
29 (Thorne) ...	...	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham) ...	...	J. T. Clow, M.B., B.S., D.P.H.

Departmental Medical Officers and School Medical Officers—

Division No. and Name

1 (Skipton) ...	...	*Helen M. Dean, M.B., CH.B., D.P.H. *G. H. Cooper, M.B., CH.B. *Shirley Jessop, M.B., CH.B., D.P.H.
3 (Keighley) ...	...	*Doreen E. Gledhill, M.B., CH.B. *J. I. Bennet, M.B., CH.B.
4 (Shipley) ...	...	*Adaline N. Ambler, M.B., CH.B.
5 (Horsforth) ...	...	*Helen M. Mitchell, M.B., CH.B. Agnes A. Crone, M.B., CH.B., D.C.H. Joan M. Murdoch, L.M.S.S.A.
7 (Harrogate) ...	...	*Isobel B. Alexander, M.B., CH.B., D.P.H. *Gertrude M. Polson, B.SC., M.B., CH.B., D.OBST.R.C.O.G. P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. A. W. I. Hall, M.B., B.CHIR.
9 (Rothwell/Wetherby)		*J. Briffa Boothman, M.D., D.P.H. *S. H. Brock, M.B., CH.B., D.P.H. Teresa Rose, M.B., B.S., M.R.C.S., L.R.C.P.
10 (Goole) ...	...	*Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H. Eileen M. R. Bell-Syer, M.B., B.S.
11 (Castleford) ...	...	Judith A. Fraser, M.B., B.CH., M.R.C.S., L.R.C.P.
12 (Pontefract) ...	...	Sheila F. Schofield M.B., CH.B., D.P.H., D.C.H.
13 (Morley) ...	...	*Barbara Briggs, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B. Doreen M. M. Anderson, M.B., CH.B.
15 (Spenborough)	...	*Lorna Arblaster, M.B., CH.B., D.P.H. *Freda M. Cox, M.R.C.S., L.R.C.P., D.P.H. Emma M. H. Holdsworth, M.B., CH.B. Alexandrina McPheat, M.B., CH.B., D.P.H.
18 (Calder Valley)	...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. Jennifer P. Bradnock, M.B., B.S., M.R.C.S., L.R.C.P. D.OBST.R.C.O.G., D.C.H. W. C. McKerr, M.B., CH.B., B.A.O.

Departmental Medical Officers and School Medical Officers—continued

20 (Colne Valley)	...	*Annie L. J. Cusack, B.A., M.B., B.CH., B.A.O., D.P.H. *L. Lloyd-Evans, M.B., CH.B. G. D. Rowarth, M.B., CH.B.
22 (Wortley)	...	Melba R. McGinty, M.B., CH.B. R. V. Read, M.R.C.S., L.R.C.P., D.P.M.
23 (Hemsworth)	...	*Edith E. Cromb, M.B., CH.B., D.P.H. *Josephine Hayes, M.B., CH.B. C. H. Merry, M.R.C.S., L.R.C.P.
25 (Barnsley)	...	Vacancy
26 (Wath upon Dearne)	...	*Margaret E. J. Bolsover, M.B., CH.B. *S. K. Pande, M.B., B.S., D.P.H.
27 (Doncaster)	...	*J. A. Beal, M.R.C.S., L.R.C.P., D.P.H. Elizabeth R. M. Harvey, M.A., M.B., B.CHIR. Joyce K. Howarth, M.B., CH.B., D.C.H.
29 (Thorne)	...	Vacancy
31 (Rotherham)	...	Mary J. Daly, M.B., B.CH., B.A.O., DIP.L.M. Patricia J. Elson, M.B., B.S. Margaret J. Hallinan, M.R.C.S., L.R.C.P.

172 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 21·7 whole-time Departmental Medical Officers.

* Senior Departmental Medical Officers.

Chest Physicians—(Joint Appointments with Hospital Services) —

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
J. J. Danaher, M.B., B.CH., B.A.O.
F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
J. D. Stevens, M.D., B.SC., M.R.C.S., L.R.C.P.

LEEDS REGION

D. J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.P., M.R.C.S.
H. Grunwald, M.D. (Vienna)
W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
W. H. Helm, M.R.C.P., M.R.C.S.
J. W. Jordan, M.D., B.S., L.R.C.P., M.R.C.S.
M. J. Livera, M.D., B.S., M.R.C.P.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
Marjorie S. Oxley, M.B., CH.B., T.D.D.
J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., CH.B., M.R.C.P.
J. Viner, M.B., CH.B.
J. Y. Walker, M.B., CH.B., D.P.H.
A. Weleminsky, M.D. (Prague)

Other Medical Specialists in the School Health Service (Regional Hospital Board and University Appointments)—

OPHTHALMIC

N. N. Agarwell, M.B., B.S., F.R.C.S., D.O.
S. K. Banerjee, M.B., B.S., D.O.
M. A. Davies, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
S. B. Davies, L.R.C.P., L.R.C.S., D.O.
M. K. Godbole, M.B., B.S., D.O.
R. Hawe, M.B., CH.B., B.A.O., D.O.
M. A. C. Jones, M.B., CH.B., F.R.C.S., D.O.
S. M. Kamaluddin, M.B., B.S., D.O.M.S.
B. A. Marshall, M.B., CH.B., D.O.M.S.
N. L. McNeil, M.B., B.S., M.R.C.S., L.R.C.P., D.O.M.S.
K. H. Mehta, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
K. K. Prasher, M.B., B.S., D.O.
T. B. Priestley, M.R.C.S., L.R.C.P.
S. Robertson, M.B., CH.B., D.O.M.S.
E. S. Tan, M.B., CH.B., D.O.M.S.
C. W. Thornhill, F.R.C.S., L.R.C.P. and L.M., L.R.C.S.I. and L.M., D.O.
L. Wittels, M.D. (Vienna), D.O.
J. L. Wood, M.R.C.S., L.R.C.P.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S., L.R.C.P.
K. S. Davies, M.B., CH.B., F.R.C.S., L.R.C.P.
J. G. Gill, V.R.D., M.B., B.CH., F.R.C.S., D.OBST., R.C.O.G.
N. Grewal, O.B.E., F.R.C.S., M.CH.ORTH.
G. F. Hird, M.B., CH.B., F.R.C.S.
G. Hyman, M.B., CH.B., F.R.C.S.
P. Kilburn, M.B., CH.B., F.R.C.S., M.CH.ORTH.
Miss P. A. I. Macleod, B.SC., M.B., CH.B., F.R.P.S., F.R.A.C.S.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.ORTH.
Miss M. A. Pearson, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.
J. Wishart, M.B., CH.B., F.R.C.S.

E.N.T.

P. J. Batchelor, M.B., B.S., F.R.C.S., D.L.O.
H. K. Das, F.R.C.S., D.O.
R. D. Dunsmore, M.B., B.S., M.R.C.S., L.R.C.P.
W. M. S. Ironside, M.B., CH.B., F.R.C.S.
S. Kavanagh, L.R.C.P.I. and L.M., F.R.C.S., D.L.O.
S. P. Mahatme, F.R.C.S.
K. M. Mayhall, M.A., M.B., B.CHIR., F.R.F.P.S., M.R.C.S., L.R.C.P., D.L.O.
H. Morus-Jones, M.C., M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.
J. E. Rees, M.R.C.S., D.L.O.
W. L. Rowe, M.B., CH.B., F.R.C.S.

PAEDIATRIC

C. S. Livingstone, M.R.C.P., D.C.H.
E. M. O'Neill, M.D., M.R.C.P., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
L. J. Prosser, M.B., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S., D.C.H.
G. Rajan, M.R.C.P.
A. P. Roberts, M.B., B.S., M.R.C.P., M.R.C.S., D.C.H.
C. M. Tiwary, M.B., B.S., D.M.B.E., M.R.C.P.(Edin.), M.R.C.P.(Glasgow)

CARDIAC

J. R. Fountain, M.D., M.R.C.P., M.B., CH.B.
P. C. Raynell, D.M., B.CH., M.R.C.P.
W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S., L.R.C.P.

DERMATOLOGICAL

W. E. Alderson, M.A., B.M., B.CH.

PSYCHIATRIC

Elizabeth Gore, M.D., CH.B., D.OBST.R.C.O.G., D.P.M.
S. Hoyes, M.R.C.S., L.R.C.P., D.P.M., D.P.H.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

CHILD GUIDANCE SERVICE

Psychologists P. W. Atkinson, B.A.
F. A. Brown, B.A.
A. B. Castle, B.A.
J. B. Mannix, M.ED.
P. J. Monaghan, B.A.
D. G. Pickles, M.A.
R. I. Pilkington, B.A.
J. C. Scott, B.A.
H. B. Valentine, M.A.

9 Psychiatric Social Workers (7 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.

17 Speech Therapists (10 part-time).

DENTAL SERVICE

Chief Dental Officer, Principal

School Dental Officer ... H. Taylor, L.D.S.

County Orthodontist G. A. Thompson, B.CH.D., L.D.S.,
Dip. Orth. R.C.S.

Dental Specialist M. R. Hollings, F.D.S., B.CH.D.

Senior Clinical Dental Officers W. A. Allen, B.D.S.

J. M. Enderby, L.D.S.

Joyce Neden, B.D.S.

F. H. Sanderson, L.D.S.

Area Dental Officers ...	...	J. R. Clayton, B.CH.D., L.D.S. K. R. Cowell, B.CH.D., L.D.S. E. Doherty, B.D.S. P. F. A. Eltome, L.D.S. J. D. Franks, L.D.S. Mary M. Gibson, L.D.S. Valerie P. Lindsay, L.D.S. E. Lowery, B.D.S. A. S. Metcalfe, L.D.S. E. S. Midgley, L.D.S. S. Mitchinson, L.D.S. J. Naftalin, L.D.S. M. S. Ormesher, B.D.S. B. Sleight, B.CH.D. H. G. Thorpe, L.D.S. H. M. Yuile, L.D.S.
School Dental Officers	...	M. J. Boyles, L.D.S. A. Brooke, L.D.S. M. Davidson, L.D.S. Joan M. Davison, L.D.S. W. H. Dyke, L.D.S. T. C. Dykes, B.D.S. R. F. Grainger, B.CH.D., L.D.S. Carole M. Hancock, B.D.S. Patricia A. Harrison, B.D.S. M. Hattan, L.D.S. D. H. Hoyle, B.CH.D., L.D.S. Margaret A. Kaye, B.D.S. F. Kershaw, L.D.S. J. M. Laurent, B.D.S. R. B. Lawrence, L.D.S. M. J. Limb, B.D.S. C. F. Martin, B.CH.D., L.D.S. D. B. Owen, L.D.S. M. J. Prendergast, B.D.S. Jessie Rothera, L.D.S. Susanne E. Schloss, L.D.S. P. Smith, L.D.S. E. Thornton, L.D.S. T. O. Tweedie, L.D.S. J. G. N. Wills, L.D.S.
6 Dental Auxiliaries		
Chief Dental Technician...		K. A. Battersby
7 Technicians		
4 Boy Dental Apprentices		
63 Dental Surgery Assistants		

NURSING AND MIDWIFERY

County Nursing Officer ...	Marjorie G. Atkinson, D.N., S.R.N., S.C.M., H.V. CERT., D.T. (Queens)
Deputy County Nursing Officer	Naomi I. Harris, S.R.N., S.C.M., H.V. CERT., D.T. (Queens)
Non-Medical Supervisor of Mid- wives ...	Dorothy Whitaker, S.R.N., S.C.M.

- 17 Divisional Nursing Officers.
- 290 Health Visitors and School Nurses (22 part-time).
- 112 Assistant Health Visitors (56 part-time).
- 2 Orthopædic Nurses and Physiotherapists (2 part-time).
- 4 Tuberculosis Visitors.
- 4 Venereal Diseases Social Workers (Qualified Health Visitors).
- 323 Home Nurses and Home Nurse/Midwives (27 part-time).
- 170 Midwives (15 part-time).
- 5 Matrons and 30 other nursing staff at 5 Day Nurseries.
- 9 Social Workers.
- 11 Trainee Social Workers.

MENTAL HEALTH SERVICE

Psychiatric Social Worker-Tutor Maria Farrow, A.A.P.S.W.

Senior Mental Welfare Officers
 R. Aspinall
 Margaret M. de la Cour
 A. Emmerson
 J. G. Jarvis
 Dorothy W. Lynes
 S. Parkinson, A.A.P.S.W.

- 56 Mental Welfare Officers
- Organiser of Training ... Frances E. Woolley, DIP.N.A.M.H.
- 1 Peripatetic Advisory Instructor
- 19 Supervisors in Mental Health Training Centres
- 133 Assistant Supervisors and other assistant staff
- 11 Cadets
- 3 Home Teachers for (Mentally) Subnormal Children (2 part-time)
- 4 Wardens in Mental Health Hostels
- 7 Assistant Wardens in Mental Health Hostels

DOMESTIC HELPS

2 Domestic Help Organisers
3,292 Domestic Helps

PUBLIC HEALTH INSPECTORS

Chief County Public Health Inspector ... D. Greenwood, M.A.P.H.I.
County Public Health Inspectors ... J. D. Clayton, A.R.S.H., M.A.P.H.I.
D. Jagger, M.A.P.H.I.
2 Pupil Public Health Inspectors
2 Milk Sampling Officers

HEALTH EDUCATION

Health Education Officer ... Mary Tattersall, D.N., S.R.N., S.C.M., H.V. CERT.,
D.T. (Queens)
1 Health Education Technician

ANALYSTS

County Analyst ... R. Mallinder, B.SC., F.R.I.C. (part-time).
Deputy County Analyst ... J. C. Harrel, F.R.I.C. (part-time).

ADMINISTRATIVE AND CLERICAL

Chief Administrative Officer ... G. Richardson, D.P.A.
Sectional Administrative Officers... J. H. Milne, D.P.A.
H. Beatson
W. J. Battye
R. S. Marshall
T. Myton, D.P.A.
T. R. Schofield, D.P.A.
J. W. Ibbotson
Administrative Officers ... E. Brown
H. V. Brook
D. Marshall, D.P.A.
D. Ramsbottom
J. Spruce, D.P.A.
P. Ward, D.P.A.

22 Divisional Administrative Officers

365 Other Clerical Staff (including part-time)